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ABSTRACT

The semiannual report describes activities of an interdisciplinary program for 6- to 12-year-old children with behavior problems. Chapters are devoted to data on the four objectives of the project: to discover ongoing behaviors that may lead to future antisocial behavior and result in a maladaptive life style, to develop a comprehensive treatment program to correct antisocial development as soon as possible, to develop new and coordinate existing resources, and to measure the effectiveness of the work. The bulk of the document provides information on the treatment program, including descriptions of the career awareness program, affective learning class and muscular relaxation training. Two detailed case studies are included with charts of behavioral programs for both students. Among program evaluation data reported are followup statistics indicating that 2 years after treatment 42% of the children served were functioning at an acceptable level. Two final chapters list project management and personnel and present an expenditure analysis as of December 31, 1976. (CL)

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THE PENDLETON PROJECT

SEMI-ANNUAL NARRATIVE REPORT

DJCP GRANT #76-3411

Submitted by

Richard C. Pooley, Ph.D.

to

The Division of Justice and Crime Prevention

Richmond, Virginia

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Virginia Beach, Virginia

January 10, 1977

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For the seventh time, and more than ever, it is appropriate to acknowledge the entire staff of the Pendleton Project for their dedication and hard work which makes this project a success. They have chosen a career field that is difficult at best, and in which the extrinsic personal rewards for exemplary work are sometimes meager or absent. In spite of this sometimes thin reinforcement schedule, they have demonstrated steadfast efforts to improve the quality of life for those they serve. Their names are listed in Chapter V.

Thorough reporting requires an extra effort. I wish to mention the names of those who have made a specific contribution to this report. Others have served in a similar capacity in the production of previous project reports. For more than a year, William G. Cunningham of Old Dominion University has worked closely with Bong-soo Eun and myself in the work being done to develop a highly efficient diagnostic-prescriptive-treatment mechanism. The status of this task is reported in Chapter I. Several staff members assisted in preparing the materials that appear in the text. Mary Johnson, Cathy Chapin, Ann Ackerman, and Bong-soo Eun provided the basic information for the case studies that appear in Chapter II. Lonnie Mooney, Debbie Johnson, Billie Walker, Susan Woolf, Peter Prizzio, Raymond Bloomer, and Rosemary Spinelli assisted Richard Shea in compiling the data that appear in the tables throughout the

text. Several Residential Treatment Team (RTT) members produced the original descriptions of the elements of residential treatment. They are Donna Beckett, Academic Program; Henry Lee, Career Awareness; Ann Ackerman, Social Skills and Affective Learning; Craig Johnson, Recreation Program; Fred Rowlands, RTT descriptive statistics; and Bong-soo Eun, biofeedback.

As a result of an outside evaluation by the Touche Ross Public Accounting firm, increased emphasis has been placed on long-range planning for project goals. Thanks goes to Alan Davidson for his part in developing a management by objectives scheme (Chapter IV) specific to this project's operation. Mr. Davidson together with Alison Ruttenburg are to be acknowledged for the financial reports that appear in Chapter VI. A final word of thanks goes to Rosemary Spinelli who diligently typed the several drafts necessary in order to produce this report.

This project was made possible in the first place by many people who are sincerely interested in improving the quality of life. The project is grateful for their continued support and advice over the years. These people are too numerous to mention individually, but it is possible to give thanks to the groups instrumental in this service. They are the governing bodies of the Cities of Chesapeake and Virginia Beach; the state senators and delegates who represent these and other localities in the general assembly; the Project Management Board and its officers; the Citizen's Advisory Council; the

State Departments of Human Affairs and Education; the Division of Justice and Crime Prevention together with the U. S. Law Enforcement Assistance Administration. We are proud to be associated with these groups in the task of human service delivery.

Richard C. Pooley, Ph.D.
Project Director

PREFACE

This report is the seventh in a series of semi-annual progress reports on the Pendleton Project since the operational phase began in June, 1973. Reports prior to June, 1973, consisted of one or two page documents which summarized the activities of the planning phase of this project.

The first operational report was submitted on January 4, 1974. It summarized project build-up in terms of staff appointments, building construction, preliminary trial of outclient service delivery and the current appointments of management board and its committees. The philosophy of the project was summarized together with current diagnostic, treatment, and training activities. All previous planning reports were included as well in an appendix to the report (January, 1974). That report serves as an historical review of the early developmental stages of the project.

The second operational report was submitted on July 10, 1974. It again reported on staff build-up and training and management board membership. Tooling-up of the physical plant including equipment and materials was summarized. The development of the residential day care program and its results together with the continuing development of outclient services was presented. The build-up of activities in community relations was specified. During this period, some internal personnel management problems developed. Problem analysis and management action together with a modified internal management structure was

reported here (July, 1974). That report emphasizes the second stage of operational development and the problems associated with such growth.

The third operational report was submitted on January 10, 1975. Management board members and associated committees together with staff distribution was again specified. The planning and development of the 24-hour residential treatment program and associated services were presented in detail. Anecdotes of eight typical cases were presented together with behavioral data to support the claims of outcome. Descriptive statistics and research results of all treatment activities were reported including our expanding use of community resources (January, 1975). That report delineates the approach to and the establishment of the project as a novel, full-blown human service delivery system.

The fourth report, July 10, 1975, is similar in nature to the previous report (January, 1975). It updates descriptive statistics of treatment activities, training, agency involvement, and public relations. On June 12, 1975, the project was visited by two representatives of the General Accounting Office, Washington, D. C. They appeared to be favorably impressed with our work. During this reporting period, full-scale treatment delivery has been maintained and refined. These activities will continue throughout. Agencies elsewhere have begun to express a strong interest in our work and indicate that they hope to replicate the process in their communities. In addition to this,

developmental emphasis has been placed on the design and implementation of refined measurement techniques in order to assess the effectiveness of project procedures. Future plans include the development of a system that can identify, diagnose, and treat children in trouble. The system is intended to administer this process with a high flow-rate of clients and a high degree of success. Our objective is to establish procedures that will effectively divert children in trouble from the juvenile justice system to a productive life in the community.

The fifth report summarized project activities for the interval of July 10, 1975 to December 31, 1975. This period was characterized by program refinement, improved service delivery, and enthusiastic public interest and support. The internal management structure was strengthened by a more detailed organization design. The American Public Welfare Association (APWA) gave national recognition to the Pendleton Project for creative and administratively sound contributions to the development of programs to serve children in trouble. A paper on the management design of the project (Pooley, 1975) was presented by the project director at the APWA National Conference in New Orleans. The project was reviewed by the U. S. Department of Justice, Law Enforcement Assistance Administration, National Institute of Law Enforcement and Criminal Justice for Exemplary Project Status. Future reports will present the progress in this effort.

The sixth report presented project activities for the interval of December 31, 1975 to June 30, 1976, with some reference

to previous periods. The project objectives were stated together with the data that supports each objective. Most sections updated ongoing activities that are routinely reported. Some new areas of investigation were included as well. For example, Chapter II presented health-related data that was not previously available. Chapter IV elaborated on some characteristics of the treatment population and treatment effectiveness. Newly established methods of treatment, such as relaxation therapy were discussed. The statistical significance of the outcomes of procedures routinely used were reported as well. Chapter IV had a section on the progress of our mini-research efforts. Four mini-research projects with from two to four replications each were reported.

This document reports on project activities between July 1, 1976 and December 31, 1976. The reporting format for the now routine treatment activities are presented in a format similar to that of previous reports. Some new developments are explained as well. First among these is a concise status report on our ongoing effort to develop a reliable diagnostic-prescriptive-treatment mechanism (Chapter I). The characteristics of the treatment population are presented in Chapter II together with descriptions of a variety of treatment approaches. Case studies are included as examples of the treatment alternatives. The development of resources together with information dissemination is recorded in Chapter III. Treatment effectiveness, the

results of an extensive outside evaluatin of the total project and future plans for project goals are the subjects of Chapter IV. Personnel and Finance reports follow in Chapters V and VI.

CHAPTER I

Introduction

The Pendleton Project is an interdisciplinary treatment program for children in trouble. The project serves the localities of Chesapeake and Virginia Beach (610 square miles) in Southeastern Virginia. It is a community-based treatment center directed toward reeducating children with behavioral problems and their families such that future maladaptive behavior is unlikely to occur.

Emphasis is placed on treating those behaviors that suggest antisocial development and which are likely to result in the need for some kind of intervention. The project resources are designed to treat behavior disorders that may be a function of inappropriate learning, perceptual or learning disabilities, or emotional adjustment difficulties. The project's intention is to intervene where antisocial behavior exists, whenever reasonable and proper, early enough to prevent or reduce the necessity of contact with other human services such as juvenile justice, social services, mental health, etc.

The project has developed diagnostic treatment procedures directed toward making children in trouble and their families socially competent so that they may funtion within the social order more effectively. They are taught ways to solve the problems of living.

The objectives may be stated as: (1) to develop a diagnostic-prescriptive system which will allow for the identification

of major underlying causes of dysfunctional behaviors, the classification of common underlying causes and behavioral problems, and finally, the development of treatment programs which are most effective for children who share common casual characteristics and behavior problems (2) to develop a comprehensive treatment program to correct antisocial development as early as possible (3) to discover ongoing antecedent behaviors that may lead to future antisocial behavior and result in a maladaptive life style (4) to develop new resources and coordinate existing resources (5) to measure the effectiveness of the work.

OBJECTIVE I. TO DISCOVER ONGOING BEHAVIORS THAT MAY LEAD TO FUTURE ANTISOCIAL BEHAVIOR AND RESULT IN A MALADAPTIVE LIFE STYLE

Summary

Data is collected on every subject and family receiving Pendleton treatment. The data consists of 834 variables and intentions are to collect data on more than 700 subjects for analysis. This task is being accomplished in concert with a subcontract with Old Dominion University (ODU). The objective of this effort is to develop an efficient diagnostic-prescriptive-treatment mechanism.

Rationale

The underlying assumptions, evaluation designs, and statistical procedures used for this effort are reported in detail in earlier semi-annual reports (Pooley, 1976a; Pooley, 1976b)

and an ODU Research Foundation report (Cunningham, 1976). A review and the current status of this work is reported here.

In medicine and other forms of treatment programs, comprehensive studies of causes must be made to determine why specific forms of illnesses exist. It is difficult, at best, and most of the time impossible, to come up with consistent cures for illness until the actual cause for that illness has been isolated and identified. The work at the Pendleton Project is based on this very simple but basic premise. It is difficult or impossible to treat antisocial behaviors without some common understanding of the causes of those behaviors and a scientific base of the selection of the appropriate treatment method.

For this reason, the Pendleton Project is collecting data on the background characteristics of Pendleton children and their families for the purpose of an accurate description of the child and his life space. Children who then share common background characteristics can be classified as to similarity of personality, background, and dysfunctional behavior. This data can then be examined to isolate and identify unique characteristics shared by some students, but which are not present among other types of children. These characteristics will then be examined more closely to determine if a causal relationship can be established. The treatment programs that have been most effective with the students who share common characteristics will then be used as prescriptive programs for other children who are identified as having similar personality, background,

and dysfunctional behaviors. Therefore, a diagnostic-prescriptive-treatment mechanism may be tested.

In order to effectively treat a disorder of any sort, the practitioner must have a clear understainding of exactly what is to be treated. Then he or she may prescribe and/or carry out the appropriate procedure(s) to correct the situation. Then, follow-up should be done to determine whether or not the procedure is working. If it isn't, then changes are made as indicated by the follow-up investigation and necessary modifications are made to the diagnostic-prescriptive system.

The treatment of behavior disorders (i.e., acting out) or dysfunctional families is no exception to this rule. The acting-out child is characterized by behaviors such as excessive fighting, defiance, property destruction, tantrums, poor academic achievement, etc. Accordingly, the Pendleton Project has designed a reasonable and potentially effective method of addressing the problem. Considerable attention has been given to the development of a workable diagnostic-prescriptive tool because the acting-out child..."is considered to be the most difficult of all child patients to treat." (Kay, 1976).

Method

Pendleton Project has treated and collected data on 572 families who have been referred to us. Similar data has been collected on a control sample (N=53). The data set is very extensive, consisting of 834 demographic, behavioral, developmental and personality variables. These data are analyzed

to accomplish three objectives: (1) to determine the characteristics that separate the control group from the treatment population (2) to eliminate those variables that have little or no diagnostic value and (3) to cluster the remaining variables such that they identify children who share characteristics common to specific dysfunctional behaviors and treatment approach, and yet who are significantly different from children who share other common characteristics and functional or dysfunctional behaviors. Thus, discreet subgroupings are arrived at from a diagnostic point of view. The number of various subgroups that will be identified is still not known. The next step will be to examine the kinds of treatment(s) that were administered to each subgroup for similarity.

If similarities exist in the treatment(s) that worked within each subgroup but are dissimilar among each subgroup, then we have a parsimonious diagnostic-prescriptive-treatment mechanism that is easily understood and efficiently administered. Children are classified as to subgroup and then the treatment that has proved most effective for that subgroup in the past is used to treat the new child.

Outcomes

As a result of this process, a diagnostic questionnaire may emerge that has only those items that are relevant to our purpose. It is anticipated that the present 834 items can be reduced to less than 300 that are very powerful indicators of subgroup characteristics. When a family completes the

questionnaire and it is scored, they may be assigned to a treatment category that has worked in the past.

Clearly, this process reduces guess work, it has a high degree of clarity, and it identifies the treatment of choice very rapidly. It should also greatly increase the probability of success since, instead of randomly choosing a treatment approach, one is selected on the basis of its success with similar types of students in the past. Thus, it is probable that the elements of the disorder are understood and treatment appropriate to correcting the problem is being delivered.

At the present time, 200 cases have been analyzed with respect to reducing the data set. The data set is currently being reduced. Initial analysis has found 45 identifying characteristics which can be used to describe Pendleton children. Other reports (Cunningham, 1976) are available which list and describe these characteristics which range from very simple descriptors to very complete ones. Examples of descriptors are: age, number of siblings, I.Q., anxiety level, popularity, self-concept, parent and/or teacher perceptions of the child (i.e., self-centered, well-behaved, etc.), negative discipline by mother, educated stepfather with young mother, unstable low socio-economic family, inactive child, working mother.

During the next six months, plans are to increase the analysis to 600 cases and to identify the subgroupings with respect

to treatment modalities. Then the performance of the reduced set of questions are to be investigated in the context of diagnostic-prescriptive-treatment effectiveness.

The outcomes of this work will be used for three purposes. The first will be internal use by the Pendleton Project and similar agencies for the treatment of children who are demonstrating antisocial behavior. The results will provide an effective model for the remediation and rehabilitation of children who are displaying antisocial behavior, before it becomes a more serious social problem. The second use might be to provide schools with a simple diagnostic-prescriptive system for children who are displaying behavior problems in the school. Teachers, counselors, and principals could use the diagnostic treatment prescriptions within the school classroom to try to improve student behavior. The last but certainly not the least effective outcome might be the development of preventive measures. Once the common characteristics that had causal effects with dysfunctional and antisocial behavior had been identified, various public services brochures and promotions could be developed for community education programs to make teenagers and young adults aware of the kind of background characteristics that can cause young children to develop behavioral problems. An example of the prevention approach might take the form "If this is the kind of homelife and background you provide for your child, you are likely to be developing a behavior problem that may cause your child to be miserable and in trouble his entire

life." The information could point out that services are available at Pendleton and elsewhere that are designed to improve the quality of life. The preventive programs could be placed in newspapers, radio, and television for the purpose of community education directed toward the purpose of prevention. All three of these outcomes are dependent on the research and treatment efforts which are now being carried on at the Pendleton Project.

CHAPTER II

OBJECTIVE II. TO DEVELOP A COMPREHENSIVE TREATMENT PROGRAM TO CORRECT ANTISOCIAL DEVELOPMENT AS EARLY AS POSSIBLE

To accomplish this objective, a variety of outclient and residential treatment programs have been developed and tested for outcome effectiveness. These programs are described here in narrative form and in the context of case studies. In order to acquaint the reader with the characteristics of the population served (see Appendix I for details) and the time frames associated with such treatment, some descriptive material is presented as a preamble to the narration on the various elements of the work.

I. Total Client Population Characteristics (8/73-11/30/76)

			Totals
A.	City		
	Chesapeake	38%	N=287
	Virginia Beach	62%	N=466
B.	Sex		
	Male	85%	N=642
	Female	15%	N=111
C.	Race		
	Black	25.4%	N=192
	White	74.2%	N=559
	Other	0.4%	N=2
D.	Service Delivery		
	Outclient only	81%	N=612
	Outclient-residential/day care-outclient sequence	19%	N=141
E.	Total referrals	100%	753

II. Residential Population Characteristics (10/74-12/76)

A. Total number of inclients: N=147

Virginia Beach children: N=81

White: 94%
Black: 6%

Chesapeake children: N=66

White: 67%
Black: 33%

Overall racial ratio across cities

White: 75%
Black: 25%

Age = 6-12 years ($\bar{X}$=10)

Ages 10, 11, 12: 67%
Ages 6, 7, 8, 9: 33%

Average treatment days: 35 (approximately 7 weeks)

B. Caseload Statistics (7/1/76-12/1/76) N=53

Number of residential children: N=27
Number of day care children: N=26

Ages 10, 11, 12: 68%
Ages 6, 7, 8, 9: 32%

Virginia Beach children: N=34

White: 97%
Black: 3%

Chesapeake children: N=19

White: 79%
Black: 21%

Inclusive racial ratio

White: 90%
Black: 10%

Average treatment days: 30 (approximately 6 weeks)

Actual and Potential Status and Criminal Behavior

Children who are referred to the Pendleton Project exhibit a variety of behavioral problems ranging from actual status and

criminal offenses, to status and criminal behaviors which, if detected, would result in police or court contact, to seriously disruptive behaviors in the home and classroom. Some of the children have also been before the court for custody proceedings.

TABLE II-1 ACTUAL AND POTENTIAL INVOLVEMENT WITH CRIMINAL JUSTICE SYSTEM*

	# of Cases	%	CF	CP
A. Actual Law Enforcement Contact for Status Offenses	50	6.5	50	6.5
B. Actual Law Enforcement Contact for Criminal Offenses	108	14.2	158	20.7
C. Actual Law Enforcement Contact for Status and Criminal Offenses	42	5.5	200	26.2
D. Potential Status Behaviors	120	15.8	320	42.0
E. Potential Criminal Behaviors	83	10.9	403	52.9
F. Potential Status and Criminal Behaviors	63	8.3	466	61.2
G. Custody Proceedings with No Other Court Contact	53	6.9	519	68.1
H. Serious Disruptive Behaviors but No Potential or Actual Offenses	244	31.9	763	100.0

*These categories are mutually exclusive so that each case is recorded in one category only.

Table II-1 indicates the number of children referred to the Pendleton Project who have been charged with actual offenses (26.2%) or who have exhibited potential status and/or criminal behaviors (35.0%), as well as the number of children referred who displayed neither status nor criminal behaviors, but exhibited antisocial behaviors at a high frequency (31.9%).

Pendleton treatment efforts must be directed to a broad range of problems, from the seriously disruptive child to the child who has committed actual status and criminal offenses.

Caseload Ratio

Each Project Service Team (PST) member has carried 12 active cases at a time, with the expectation of terminating 4 cases and opening 4 cases each month. At that rate, a PST treatment agent would work with 60 families per year and terminate 48 of them. We are approaching that objective with an average of 3.5 terminations per month for a total of 42 terminations per year per PST worker. This serves to demonstrate the efficiency of low caseload-high flow-rate delivery of service.

Duration of Treatment

The average duration of treatment (i.e., date of assignment to date of termination) for all referrals is 14.4 weeks. For those clients who receive only outclient services, the duration of treatment averages 12.8 weeks. For those more serious cases that require both outclient and residential or day care services, the duration of treatment is 23.2 weeks. The average duration of the residential phase of treatment is 30 days.

Follow-up Procedure

During the three and one-half years of development of the Pendleton Project, much of the monitoring of treatment data has focussed on the baseline and intervention phases. In March, 1976, a more systematic approach to follow-up contacts was developed by two members of the Project Services Team, Peter Prizzio and Raymond Bloomer. At that time, a monthly file card system was

introduced. When a case is terminated, the client's name is recorded on a file card for contact at 1 month, 5 months, 12 months, and 24 months after the date of termination. This establishes a monthly tickler file. At the beginning of each month, that month's file cards are photocopied and given to each PST case coordinator. The results of the follow-up contacts are brought to the third PST staff meeting each month for recording the data in the case ledger.

In September, 1976, a procedure was established for supplementing the parents' and/or teachers' verbal reports with frequency data collected on the target behaviors during the treatment phase. This additional data is collected for one week (i.e., home behaviors - 7 days; school behaviors - 5 days) at each follow-up contact for comparison. Data is then collected by parents or teachers who have been trained in behavior observation and recording procedures. Routinely, this includes those cases that have been closed with the following termination codes (see Chapter IV, p.75 for results).

01 Change in behavior such that child is able to function adequately in the natural environment, including home and school.

03 Parents unwilling to accept services after treatment program implemented.

05 School unwilling to accept services after implementation of treatment program (if teacher has been trained in data collection procedures).

06 Referred to another agency for appropriate services (if parent has been trained in data collection procedures).

07 Change of residence resulted in no further need for services for child (if parent figure has been trained in data collection procedures).

08 Change in school placement resulted in no further need for services for child (if teacher has been trained in data collection procedures).

10 Family moved outside Pendleton coverage area (if parents can be contacted).

15 Tried everything, but nothing worked.

Health Related Information

The Public Health nurse in the Project Service Team collects developmental, medical, and other health-related information on each child referred to the project.

Table II-2 is a summary of selected health-related information from a sample of 287 children referred to the project.

In addition, the nurse does a brief physical screening of each child for any observable health problems and, if necessary, refers the child to a specialist for a more extensive evaulation. One-hundred three children (23%) have been referred to a specialist (i.e., physician, dentist, or neurologist) for health-related problems.

TABLE II-2 SELECTED HEALTH INFORMATION (Sample of 287 Referrals through November 10, 1976)

1.	Family has health insurance		88.9%
	of these: have Medicaide	22.0%	
	have military coverage	33.8%	
2.	Family has used Public Health Department Services		40.1%
3.	Family has family doctor		90.0%
4.	Child has ever been seen by dentist		62.4%

TABLE II-2 SELECTED HEALTH INFORMATION continued

5.	Child has seen dentist in the last year	46.9%
6.	Child's immunizations up-to-date	86.8%
7.	Mother had problems during pregnancy (i.e., on drugs, bleeding, trauma, toxemia, large weight gain)	27.9%
8.	Mother had problems during birth (i.e., premature delivery, breathing difficulties, placenta previa, placenta abruptio, prolapsed cord)	18.5%
9.	Child has chronic illness (i.e., anemia, hearing difficulties, ear infections, rheumatic fever, heart disease, convulsions, diabetes, kidney trouble, sickle cell, mental problems)	33.1%
10.	Child has allergies	24.0%
11.	Child is currently a bedwetter	17.8%
12.	Child has been on behavior-control medication in past (i.e., tranquilizers, enuresis, anti-convulsants)	33.0%
13.	Child is on behavior-control medication at time of referral	13.2%

Self Concept

One measure of the residential treatment effectiveness is based on psychometric data before-and-after residential treatment. The Piers Harris Self Concept Scale is one such measure.

Table II-3 and Figure II-1 show that the residential children's group means on pre and post measures increased from the 36th percentile to 63rd percentile according to the scale norms which are based upon 1,138 children from 4 through 12 years old. The mean differences of the treatment sample are statistically significant (range: $p < .10$ to $p. < .0005$). The project has replicated this procedure over three such samples (Pooley, 1976b) and similar patterns have emerged with each sample.

However, as Table II-3 indicates, factors of Anxiety and Happiness and Satisfaction seemed to be somewhat resistant to the residential treatment. This may be explained by the fact that most of the residential children are, at first, homesick and unhappy when they are separated from their family. They may be basically unhappy and anxiety-ridden children due to the severity of their problem behaviors and incompetency in academics, social skills, and body movements as well. These characteristics are likely to induce unusual degrees of anxiety and unhappiness that are not easily reversed.

An experimental approach to solving these problems may be to shorten the stay in residency and to intensify or strengthen the expressive domain treatment programs, such as arts and crafts, music, recreation, social skills, affective learning, and bio-feedback-induced relaxation. The instrumental domain, such as the basic education and career awareness programs may deserve equal attention as well.

TREATMENT EFFECTIVENESS MEASURES ON RESIDENTIAL CHILDREN

TABLE II-3. PIERS HARRIS CHILDREN'S SELF CONCEPT PRE/POST MEASURES ON THE RESIDENTIAL CHILDREN (N=20 during 7/76-11/76).

Factor Dimensions of the Scale	Pre-test		Post-test		t value one-tailed
	M	SD	M	SD	
Total scale score (80 points)	48.3	14.6	58.0	13.2	4.0***
Factor I: Behavior (18 points)	9.6	3.7	11.9	3.8	2.7*
Factor II: Intellectual & School Status (18 points)	11.4	4.7	13.8	4.0	3.1**
Factor III: Physical Appearance & Attributes (12 points)	8.2	2.6	9.7	2.9	3.3**
Factor IV: Anxiety (12 points)	7.3	3.0	8.2	2.4	1.4$^{\Delta}$
Factor V: Popularity (12 points)	6.3	3.6	9.0	2.6	3.5**
Factor VI: Happiness & Satisfaction (9 points)	5.9	2.3	6.6	1.5	1.6$^{\Delta}$

$^{\Delta}$ $p < .10$

* $p < .01$

** $p < .005$

*** $p < .0005$

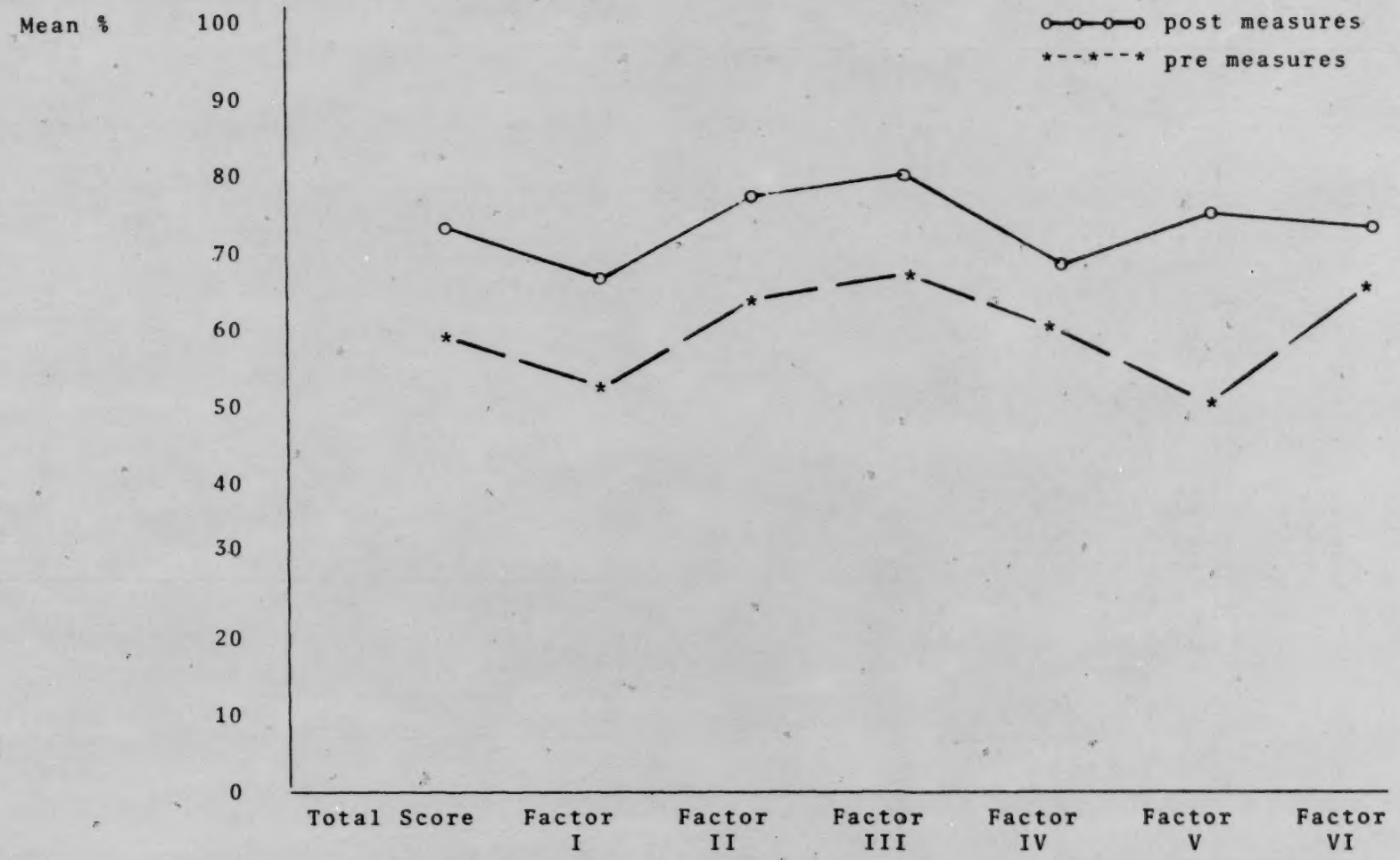


FIGURE II-1

Piers Harris Self-Concept Pre and Post Measures of Residential Children (N=20)

Academic Program

While at Pendleton, a large part of each child's day is spent in the classroom studying social skills, language arts, and math. A normal classroom setting is simulated with the main emphasis placed on the basics of language arts and math. Shortly after a child enters residency, an academic pretest is administered to determine his actual functioning level in language arts and math. The two standardized tests used are the PIAT and WRAT. From the results of these two tests, an individual academic program can be designed and administered to each student according to his need.

An analysis of our testing program shows that a large number (66%) of our students have learning disabilities. It is often necessary to administer specific learning disability tests to determine the extent of the learning problem; then, a prescription is developed to test the remediation of this problem at Pendleton. The child then may be returned to his regular school with a recommendation to use the procedure that has been found to work. Some children can work very well with the program that their regular classroom teacher has sent to Pendleton. These children seem to have behavioral problems which are culturally introduced. In such cases, emphasis is placed on appropriate home and school behaviors and problem-solving techniques. Every week, parental conferences are held to discuss each child's academic and behavioral progress and to encourage parental involvement with their child and the methods that have proven to work in the remediation of the problem behaivors. Parents are

taught or coached to strengthen the positive behaviors that are present in the child's repetoire as well.

A token economy is used to manage the classroom. Each child earns points for appropriate classroom behaviors which are traded for privileges later in the evening. Eventually, all children will be placed on a contract, and a good letter system (see Case Studies for examples). The frequency of each child's target behaviors are monitored by behavioral technicians and recorded. When a child's inappropriate behaviors have decreased in frequency and intensity to a tolerable level, he is post tested and phased out to his school with specific behavioral and academic recommendations. Each resident's teacher is encouraged to visit the project for conferences before the child returns to his home and school. Follow-up conferences are also scheduled to discuss each child's progress after he has returned to his regular class.

TABLE II-4 INTELLIGENCE TEST RESULTS FOR THE PENDLETON SAMPLE AND THE PUBLIC SCHOOL SAMPLE

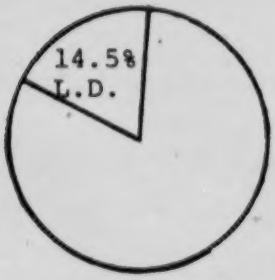
Group		Verbal				Nonverbal			
	CA	MA	SD	IQ	SD	MB	SD	IQ	SD	LD%
Pendleton	11.0	10.4	2.5	94.1	15.6	103.0	2.7	92.9	18.1	66.0
Public Health	8.9	9.8	1.1	110.0	12.2	9.5	0.9	106.0	10.8	14.5

Pendleton sample (N=32) was chosen among 110 Pendleton residential children who had complete WISC information. The public school sample (N=932) was chosen among third and fourth grade children in schools located in high level opportunity areas associated with minimum cultural deprivation (Myklebust, 1968, pp 4-9). The PMA (Primary Mental Abilities Test, Thurstone, 1948) were administered.

Interpretation of Intelligence Test Results

Learning quotients below 89 indicate higher probabilities that a learning disability may exist. It has been determined that 14.5% of the children in the public schools served attained scores below 89, whereas, 66% of the children who are referred to us for residential treatment score below 89 on intelligence tests. These data are illustrated in Figure II-2.

The public school children with learning disabilities



The Pendleton residential children with learning disabilities

FIGURE II-2

A Comparative Proportion of Learning Disabled Children in the Public School and the Pendleton Project

Career Awareness Program

Lorraine Hansen describes career awareness and career development as a reality testing which involves role identification, role taking, role exploration, assessment of self and of opportunities of the economic conditions of society (Hansen, 1969). Pendleton has adopted Hansen's theory of career awareness and development for the structural framework of our own program.

The primary aim of Pendleton's career awareness program is to change children's anti-social behavior which can possibly

result in future criminal behavior. Emphasis is placed on delinquency prevention. In response to anticipating future educational trends, and as a response to community needs, the value of career awareness is beginning to be appreciated *(Virginia Beach Beacon, 1976), (Virginian Pilot, 1976)*. Our program attempts to address some immediate daily living problems that the child may face, such as:

> Family socialization and interaction - Many children such as those who have been in institutions may have distant family ties. The knowledge of what is going on within the family may be severed beyond the realm of pre-adolescent understanding. So, understanding the role that work plays and the effects it may have on family life style and its members is important for the child to know. He may better understand the family, their goals, satisfaction and confidence. Developing respect and confidence in ones' self rests largely on how the esteem of significant others is viewed.
>
> Interest and motivation - As a motivational procedure and as an information source, career awareness has proven to rekindle interest. First, the child is able to choose what is of interest to him and then these interest areas are incorporated and correlated with the regular academic curriculum.

Mothers, as an intricate part of our work force, are important because many of our population are in homes where both parents work or without fathers.

Our career awareness program is divided into three levels: orientation, exploration, and mastery.

> Level I - Orientation is geared toward introduction of various careers in the immediate environment and involving parents in various planned activities.
>
> Level II - Exploration level deals with actual contact with various career situations and superficially allows the children to explore these situations to begin to gain insight into the world of careers.

Level III - The Mastery level allows the child to express his own ideas about career awareness and is an evaluative means of assessing how much learning has been transferred from the previous two levels. This is the independent level.

In analyzing partial test results from the *Comprehensive Career Assessment Scale*, the following results were emerged"

1) Eighty-one percent of twenty-two subjects tested reflected an increase on either the familiarity or interest portion of the career scale.

2) Nineteen percent of the subjects showed no increase or showed a decline on both the familiarity and interest portions of the scale. The assumption drawn is that when familiarity increased, the child showed more subjecting in making judgement as to whether a particular career was interesting to him, thus narrowing or increasing this interest field.

3) Fifty-nine percent of the twenty-two subjects that pre and post measures were given showed increases in both familiarity and interest of careers.

Clinical Observations

1) The children enjoy taking task with and objectively exploring solutions to problems encountered in their immediate environment. The children are involved in role taking, role identification, role exploration, and assessment of self in dealing with realistic situations of society.

2) As a more concrete picture is painted of family members' roles, especially that of work, family ties are seen to increase. The self respect and confidence gained by the child stems mainly from the fact the family is presented in a positive and necessary role. Some of the children show more responsiveness toward family role by increasing household duties and/or changing their inappropriate behaviors.

3) The incorporation of career-related materials into the regular curriculum content appears to create automatic incentive and motivation. The lessons are untraditional and are viewed by the students as fun. A student will exert much more of a positive approach in reading road signs if he is interested in a driving job than reading materials unrelated to his interest area. A student will show more motivation in attempting to figure how many squares of tile will be required to cover a floor if that is his interest than if totally unrelated to his interest.

4) When mother has to work, either from a two-parent family or a one-parent family, the child begins to see the necessity of being more responsible for himself. The realization that needed attention must sometimes be delayed is instilled. In other words, the child learns to delay or defer immediate gratification.

Social Competence Program

The evening program in the residential unit is called the Social Competence Development Program. The goal of the evening program is to teach acceptable behaviors with which to replace aggressive or maladaptive target behaviors. Hopefully, as the child receives praise for displaying these appropriate behaviors, his sense of self-worth will increase. We also aim to provide an environment for children and their parents, for practicing or rehearsing these skills.

One element of the evening program is the Social Skills Class. Here, through drills, modeling and role playing, residents work on skills which will enhance their ability to communicate with others, thus increasing the probability of receiving positive feedback. These skills include:

1. maintaining good eye contact
2. developing listening skills
3. using appropriate voice tones
4. practicing courteous manners
5. focusing attention on and remembering environmental cues
6. following directions
7. creating and evaluating alternatives
8. solving problems

Many of the individual exercises done in the social skills class focus upon saying good/positive comments about self and others. This not only directs the individual's attention to his own good qualities but also allows him to hear others speak to him in positive terms.

Parents and sometimes siblings are also brought into the social skills class, if possible. This serves several purposes:

1. Parents are made aware of the skills the child is attempting to acquire and are thus able to continue working with him on weekends at home.

2. Parents are reminded in a non-threatening way that children need to be treated with consideration and respect in order to display the same.

3. Parents, by observing the teachers in the class, are provided models in praising and other behavioral techniques.

4. Parents are allowed or required to interact with their child in a positive and constructive manner while in a structured situation.

Children brought into the residential program have behavior problems. Often, these behaviors are so severe that the child hears nothing but criticism and reprimands. It is the goal of the evening program not only to praise good behavior but also to teach the appropriate behavior that will allow others to praise him. These behaviors are then brought to the attention of the family and models of a praising adult are presented. As the child learns appropriate behaviors to replace his target behaviors, his own feelings of worth, competence, and accomplishment increase, hence, building up a child's self concept.

Affective Learning Class

The Affective Learning Class is conducted for 45 minutes, four evenings per week with every resident participating. The objectives of the class are as follows:

(1) to help residents develop an awareness of feelings and personal concerns,

(2) to lead residents toward an understanding of himself and others,

(3) to help residents vocalize and act upon personal concerns to achieve a productive outcome.

The affective learning group combines seven distinct topics toward a goal of providing effective moral decision-making skills. This is done through discussion, film strips, tapes, photo boards, and free art drawings. These are outlined below:

I. Goal Setting: Resident identifies his own behavioral goals, attempts to meet them in the home environment during the weekend, and evaluates his progress the following week.

II. Self Concept: Residents attempt to increase their awareness of themselves and understand who they are.

III. Abilities and Limitations: Residents attempt to define their assests and liabilities in terms of the realities of age and practice.

IV. Responsibility: Residents attempt to increase their awareness of what responsibility is, what it means to accept responsibility and what consequences result when one fails to fulfill responsibility.

V. Communication: Residents attempt to understand what communication involves and how it affects relationships with others.

VI. Companionship: Residents explore their need for people and qualities that make a person a good friend.

VII. Acceptance and Rejection: Residents attempt to increase their understanding of reasons for acceptance and rejection, feelings associated with acceptance and rejection, and ways of dealing with rejection.

The Affective Learning Class consists of sessions concerning moral decision making. According to Kolberg (1971), the development of moral judgement occurs in a hierarchical structure consisting of six stages. Each stage is more difficult to

comprehend than the previous one, therefore, Kolberg (1971) states that "moral education should not be aimed at teaching some specific set of morals but should be concerned with developing the organizational structures by which one analyzes, interprets, and makes decisions about social problems."

From this premise, the moral decision-making sessions are developed by the residential treatment team. The main objectives of the sessions are:

1. to establish the level development of each child in residency,
2. to introduce situations and variables that encourage moral decision making,
3. to provoke discussion concerning the premise of each decision,
4. to introduce possible alternatives related to the stage developmental hierarchy.

The composite of objectives is aimed at stimulating the development of vertical and horizontal growth in the moral decision-making stages (*Focus on Self Development, Stage Two: Responding*, Science Research Associates, Inc. 1971).

Affective Learning: Case Study on How to Teach about Human Death

Death cannot be hidden from children without adding confusion and anxiety to their already difficult world. Too often, parents, teachers, and counselors deny children the opportunity for learning about death with the rationalization that they are sparing the child feelings of grief. Most psychologists agree, however, that young children need to learn to grieve and accept death over small losses, such as pets, in order to prepare them for the greater losses that are likely to occur in their lifetime.

On October 20, 1976, a Pendleton Project residential team staff member died of cancer. The opportunity was taken at this time to educate the current residents to the reality of death. Eight children were in residence at this time, five of them had been with Doris (the deceased) only two weeks previously, three of the children did not know her. The group ranged in age from 7 to 13 years.

From the younger or less mature boys came questions regarding facts and physical realities:

1. What is cancer?
2. Where is it?
3. How did she get it?
4. Will she be buried under ground?
5. Can she still feel things?
6. Is she still breathing?
7. If she had a baby inside her, would the baby die too?

The older or more mature boys responded more on an affective level. They voiced feelings of sadness, loneliness, and anger. One boy, in particular, to whom Doris served as an advocate, took her death as rejection. Unfortunately, his mother had deserted his family three weeks earlier, his father was out to sea, and the child was in the process of adjusting to temporary foster parents and apprehensively preparing to attend a new school. His comment was, "Now I've lost another one, first my mom, and now Doris - if my dad doesn't come back...wow!"

The older boys also offered stories about the death of grandparents or their parents' friends rather than animal deaths. They also related signs of grief they had observed: crying, yelling, withdrawal, etc.

Residents of all ages spoke readily of specific events Doris had participated in, comments she had made, things she had done for the children. The class closed with a reflection of these events and a reminder of how much Doris cared for them and all Pendleton residents as well. It was agreed that she would have liked them to work hard and not be sad for too long, but instead, to find happiness and love just as they had given that to her (Clay, 1976).

Muscular Relaxation Training

Electromyographic (EMG) biofeedback procedures have been reported as effective, rapid, and reliable techniques for reducing levels of muscle and subjective tensions in clinical applications (Stoyva, J., 1973, pp. 387-406).

Application of EMG biofeedback procedures is a valuable clinical tool for learning self-control by allowing the hyperactive child to acquaint himself with those physical reactions to stress over which he formally believed he had little or no control.

As soon as any resident is identified as one who has chronic anxiety, EMG biofeedback procedure is applied and accompanied by individual counseling.

The effects of daily deep muscle relaxation, achieved through EMG feedback training have been monitored in producing short-term reductions in tension (see Case II - Danny, p. 42).

Good News Board

Another unit of the evening program which also focuses on positive elements is the Good News Board. Following the evening meal, each resident generates an item of good news which is written on a chalkboard. A resident's news can be about himself or someone or something other than himself. A vote is taken to select the best news of the day, and the contributor of that news is line leader for the evening.

The objective of the Good News Board is to place emphasis on positive rather than negative happenings. This encourages a resident not only to look for and remember positive events but also to look for these in relationship to himself and others.

The Good News Board also allows residents to hear positive statements about himself from his peers as well as from staff members (DeJarnette Center for Human Development).

The purpose of the Good News Board is to encourage residents to focus on positive elements in their environment. Two areas have been evaluated - the quality of the news and the focus of the news:

> Quality: The quality hierarchy ranges from news about routine activities to news about characteristics or traits about people.
>
> Focus: The focus hierarchy ranges from news about events and news that is self or ego-centered to news about others or social-centered news.

The six categories, listed from least socially sophisticated to most socially sophisticated, are as follows:

I. Routine and event
example: It stormed today.

II. Characteristic and event
example: The storm was scary.

III. Routine and "I" statement
example: I got sixty points today.

IV. Characteristic and "I" statement
example: I worked hard today.

V. Routine and "You" statement
example: Jim hit a home run.

VI. Characteristic and "You" statement
example: Jim had good self-control during the baseball game.

Therapeutic Recreation Program

Children who have developed maladaptive behaviors and who have not achieved satisfactory emotional maturity require appropriate therapeutic intervention that will allow them to attain mastery of themselves and their environment, experience success, and develop positive interpersonal skills. The Therapeutic Recreational Program is a complete and comprehensive program of health, physical education, movement exploration, and therapeutic social activities.

Most of the public concerns about poor health habits (i.e., drug abuse, smoking) can be addressed in a comprehensive physical education program. The very survival of some pupils attending our schools may well depend upon the success that teachers of health education have in delivering timely, accurate information to our youth. Health education may consist of activities which will favorably influence understanding, attitudes, and practices relating to individual, family, and community health. Topics covered include drugs and narcotics, smoking, personal hygiene, food and nutrition, and safety.

Physical education is defined as that part of education which is concerned with the development and utilization of the

individual's movement potential and related responses as well as with the modifications or stable behavior changes which result from these responses. In light of this definition, the Pendleton Residential Program of physical education consists of a specialized environment characterized by events intended to provide opportunity for physical, social, emotional, and intellectual responses on the part of the student so that inappropriate behaviors may be modified according to the acceptable standards of society.

Many difficulties that children experience in their efforts to participate are the result of inappropriate teacher response to those efforts. The structured environment requires more than stimuli for children to develop an appreciation for the benefits to be gained from active participation in group or individual physical activities. It requires sensitivity on the part of the teacher to accurately "read" the student's frame of reference.

The concept of a movement exploration program takes on added significance when the problems of many of our residences are considered. Most of the children (63%) referred to us have some type of learning disability, environmental disorganization, or perceptual disorders, such as: directionality, laterality, spatial relationship, perceptual motor coordination, self-identification, body localization, etc. A physical movement program is of considerable benefit in remediating some of these deficiencies. Our movement program attempts to give the child perceptual experiences in conjunction with auditory, visual, tactile, and kinesthetic stimuli to reach certain objectives.

Some of the objectives of the Therapeutic Recreational Program are:

1) To emphasize positive self concepts through participation in activities.

2) To provide an organized program of exercise.

3) To provide scientific facts about health in order to improve one's judgement in such matters.

4) To help the resident gain skills and attitudes which will assist them in using their leisure time in a positive and constructive manner, as opposed to a negative or pathological one.

5) Promote learning of motor skills and the development of speed, strength, and endurance.

6) To promote knowledge, skills, and attitudes essential to enjoying physical recreation experiences throughout one's lifetime.

Some therapeutic activities are:

1) Social activities: informal games, group discussions.

2) Entertainment: watching television, listening to music, talent shows.

3) Arts and crafts: drawing, painting, leathercraft.

4) Outdoor recreation: camping, swimming, picnicking.

5) Sports and active games: team sports, such as volleyball, softball, basketball, and dual sports, such as badmitton, shuffleboard, horseshoes.

6) Special events: barbeques, carnivals, holiday celebrations, roller skating.

Arts and Crafts Program

Purpose: The purpose of the program is to teach the residents ways in which he can use his leisure time in a positive and constructive manner.

Contingency: Residents who have demonstrated appropriate behavior at home during the weekend are allowed to participate

in arts and crafts activities. A good weekend is determined by a behavioral checklist sent home over the weekend which is evaluated by the parent(s) and the day and evening advocate. The checklist is based on a five-point scale. One point = poor. Two points = fair. Three points = good. Four points = very good. Five points = excellent. An acceptable point total is the criteria which will qualify the resident to participate in the activities. Example: If Randy gets three points from mother and a five from both the day and evening advocaté, his point total is thirteen. If he needs twelve points to participate, he has met the criteria. Anything less than twelve points eliminates him from the activity.

The arts and crafts activities are held on Monday from 6-7:15 p.m. Staff consists of the recreational director, one child care worker for monitoring behavior and assistance, and one volunteer worker.

CASE STUDIES

The two case studies presented here illustrate the treatment methods that are used by the project. The first is an example of outclient treatment. The second is a case that required both outclient and residential service.

Case I - Terry

Terry is an eight year old, third grade student who was referred by the Virginia Beach Department of Social Services in June of 1976, for physical and verbal aggression and tantrums at home. He was in a private day care program after school

and both the mother and the day care worker had difficulty in managing his behavior.

Terry was living with his mother, brother Billy 9, and the mother's boyfriend and future stepfather. His natural father was serving time in prison for child abuse and other offenses, having beaten Terry, Billy, and the mother.

The school psychologist's evaluation in January, 1976, indicated that Terry was functioning in the average range intellectually, but achievement scores indicated that he was 1 to 1½ years behind academically. A learning disability was suspected in both visual and auditory functioning. A complete physical examination was requested by the project's Public Health nurse, and his immunizations were brought up-to-date at that time. He had previously been on medication for hyperactivity.

Baseline. The mother and Pendleton Project worker jointly specified the following target behaviors: cursing, wandering off, sassing, fighting with his brother, threatening to hit mom, hitting or kicking mom, and hitting his mom's boyfriend. The mother also agreed to monitor the frequency of her spanking and praising Terry. A multiple baseline technique was employed to monitor the target behaviors.

Intervention. Cursing and wandering off were the initial behaviors chosen by Terry and his mother as the targets of intervention. A behavioral contract was negotiated, specifying the limits for cursing (2 per day) and wandering off (one per day). If Terry stayed within the limits, he earned a daily

reinforcement (bedtime snack and time alone with mom). Figure II-3 indicates that the cursing decreased rapidly from baseline (A_1) during the contract phase (B) and remained at a low rate when the contract was discontinued phase (A_2). Wandering off, Figure II-4, gradually decreased from baseline (A) to the intervention phase (B) and dropped off almost enritely when the family moved to a new neighborhood (C). Sassing, Figure II-5, was added to the contract with limits of two per day (B) and one per day (B_2). At this point, Terry contracted with his brother to limit fights, Figure II-6, to two per day (B_1) and then one per day (B_2). Staying within the specified limits resulted in a weekly reinforcement (e.g., going to drive-in movie). While the mother continued to monitor the other target behaviors (threatening to hit mom, Figure II-7, hitting or kicking mom, Figure II-8, and hitting future stepfather, Figure II-9), it was not necessary to design a specific intervention program to reduce these behaviors. They appeared to decrease as a "spin-off" of the interventions with the other target behaviors.

Concurrent with the program implemented at home, Terry was enrolled in the summer day care program at Comprehensive Mental Health Services of Virginia Beach. Much of the focus of this effort was on his aggressive classroom behavior and academic deficiencies.

When school opened in September, his teacher contacted the mother about Terry's "antsy" behavior. Terry complained to his mother stating that he disliked the teacher's yelling

behavior. The mother took it upon herself to have a conference with the teacher to explain that Terry responds favorably to praise and to suggest the use of a chart at school similar to the one used at home.

An anecdote of interest. The mother was spanking Terry one day when he asked why he was spanked so much. Taken back somewhat, the mother responded that it was because she loved him. She turned away from Terry who balled up his fist and rammed his mother in the back. The mother, furious, demanded to know why he did that. Terry, of course, responded, "Because I love you."

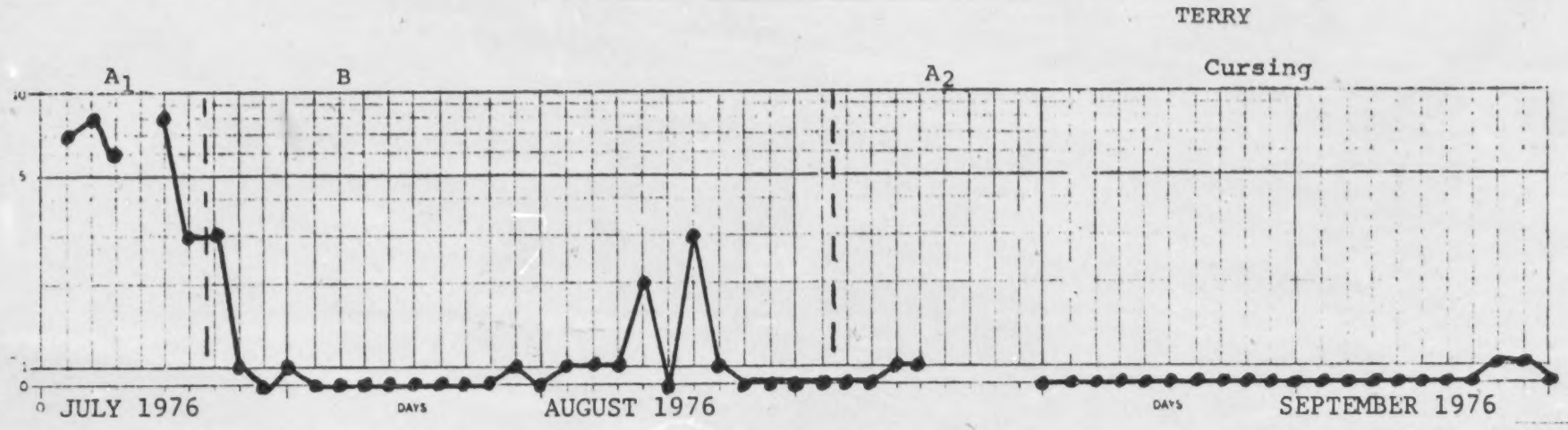


FIGURE II-3
Daily Cursing Behavior

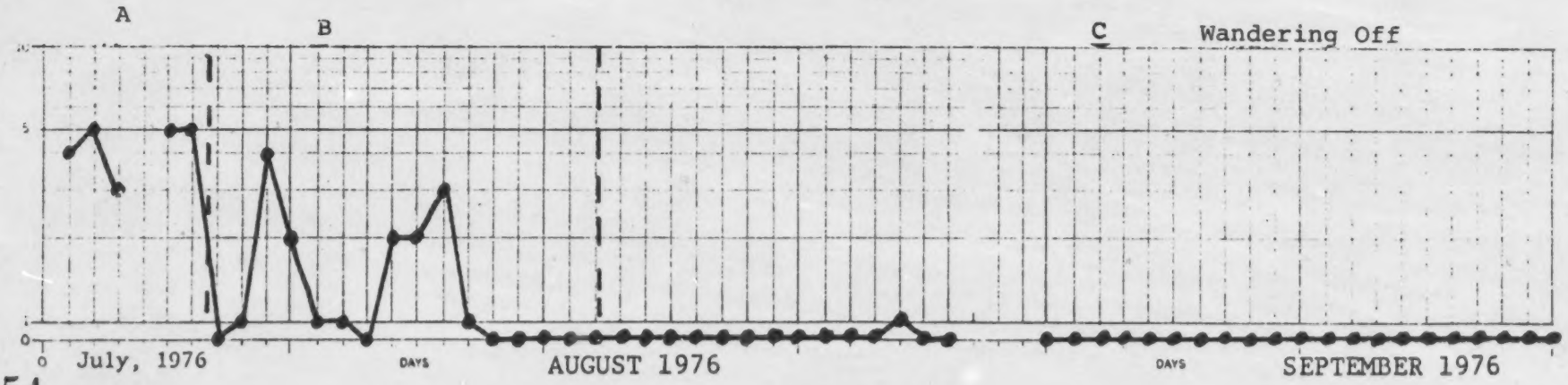


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FIGURE II-4
Daily Wandering-off Behavior

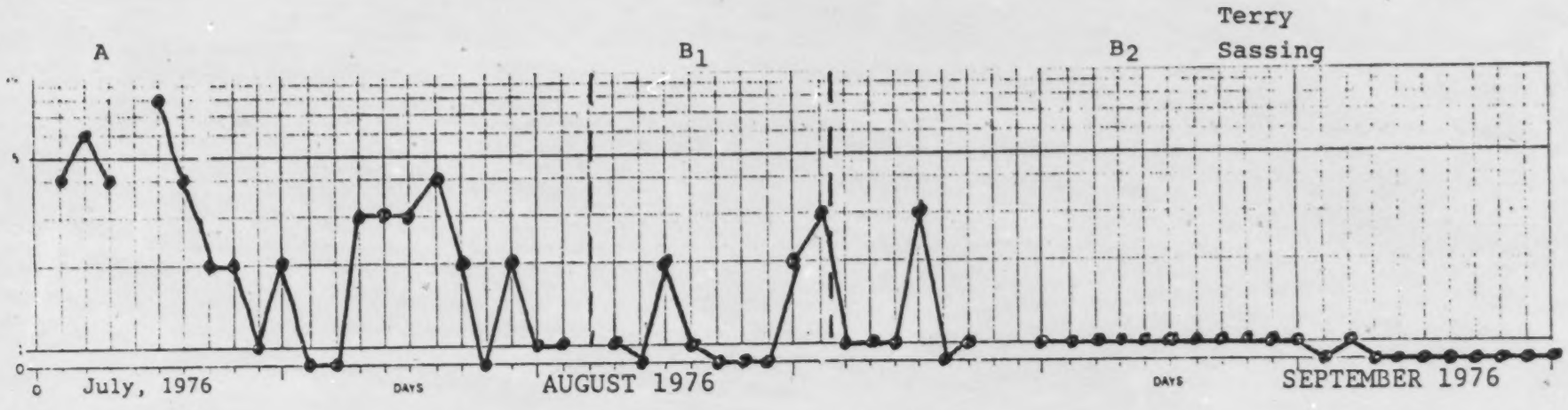

FIGURE II-5

Daily Sassing Behavior

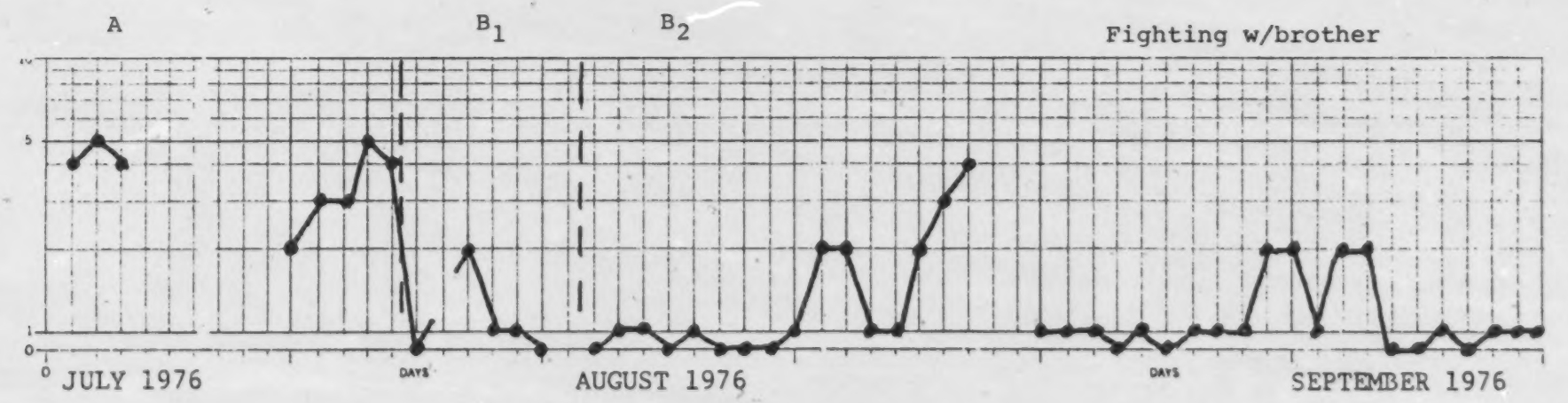

FIGURE II-6

Daily Fight With Brother

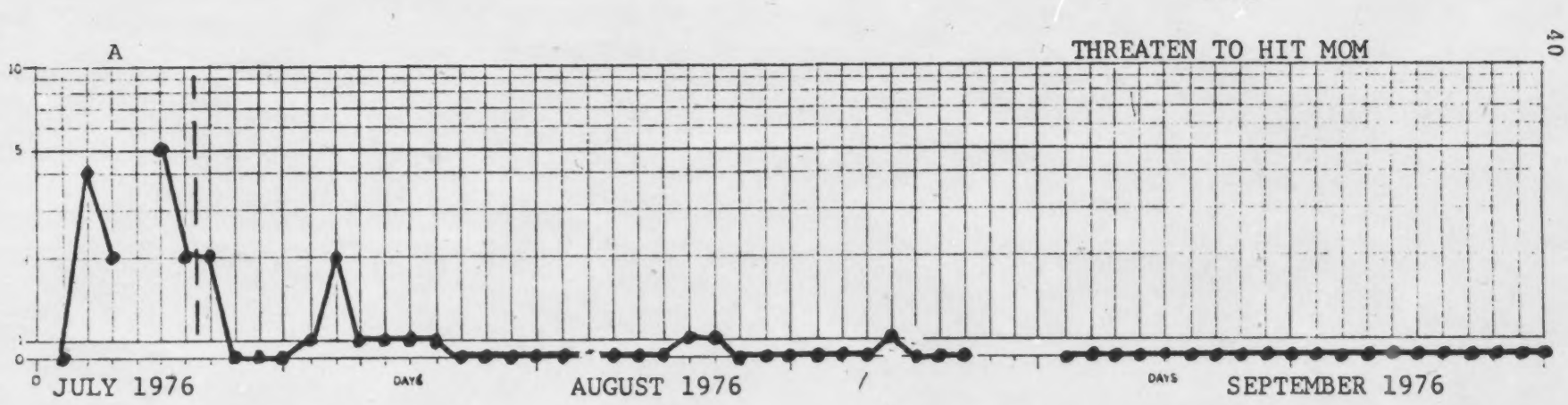

FIGURE II-7

Daily Threatening to Hit Mom

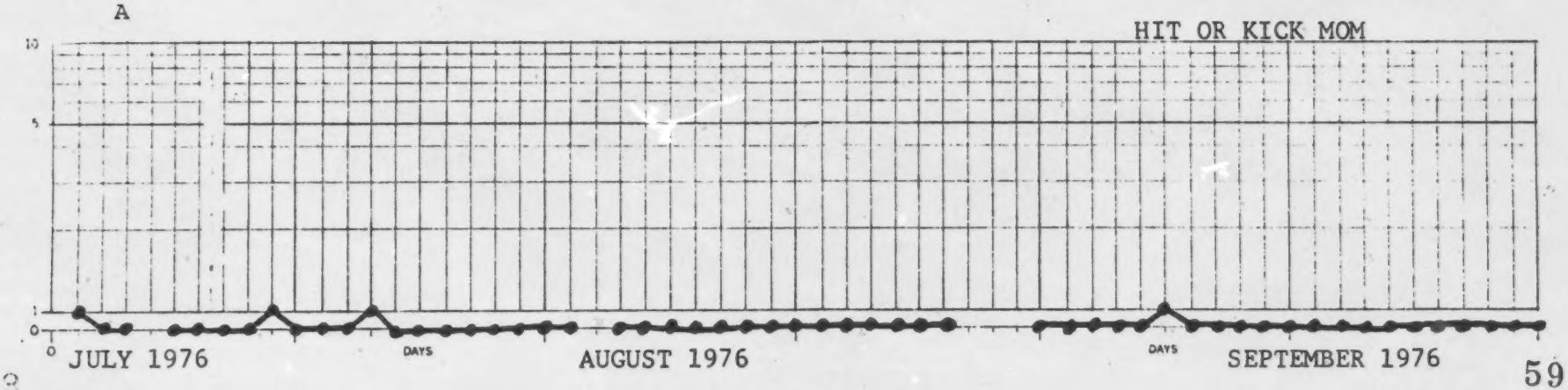

FIGURE II-8

Daily Hit or Kick Mom

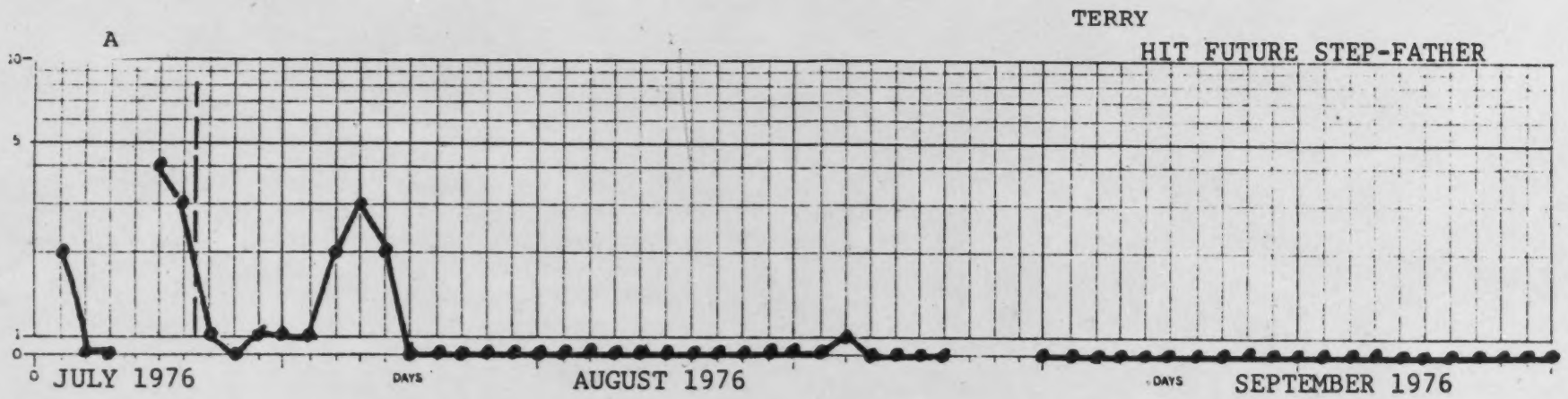

FIGURE II-9

Daily Hitting Future Stepfather

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Case II - Danny

Danny is a seven year old white male who is presently enrolled in the Center for Effective Learning in a classroom for the emotionally handicapped. He lives with his parents, Mr. and Mr. L., and one sister who is 11 years old. The family lives in a middle-class neighborhood. Mr. L. works two jobs due to medical bills for Danny and his wife. Mrs. L. is a homemaker.

Pre-residence Outclient Treatment

The initial referral of Danny to the Pendleton Project was made on February 11, 1976, by Mrs. Grace Woody, first grade teacher in the Virginia Beach Public School system. Referral behaviors included fighting, tantrums, verbal and physical aggression, destructiveness, backtalk, short attention span, hyperactivity, various phobias, extreme fantasizing, and facial tics and grimacing. Danny was taking Ritalin, 35 mgs. daily.

After referral to the project, a home note was started with reinforcement by his parents every afternoon and a bonus on the weekend. Mrs. Woody used primary reinforcers and praise every 5-15 minutes of on-task behavior in the classroom. Praise was also used at home for appropriate behavior using a shaping procedure. Time out on a chair was used for temper tantrums (see home and school graphs).

Residential Treatment

Danny was entered into Pendleton's residential unit on July 6, 1976, for nine weeks of intensive treatment. Residential

treatment was not expected to be the entire answer to Danny's problems; focus was placed on reducing his anxiety in general and with regard to specific fears as well. Danny began day care on August 30, 1976, and was phased out on September 3, 1976.

Residential Progress

When Danny entered the residential program, he had been on medication (ritalin, 35 mg. per day) since the age of three years. After the first day of residency, this medication was discontinued in order to determine the amount of self-control Danny could display on his own. Danny worked well in the highly structured point system of the residential unit.

Treatment Plan

The specific phobias dealt with during Danny's time in residence included:

1) separation from mother
2) washing hair
3) taking showers
4) physical examination
5) eating with a group of children
6) ears being touched or loud noises

1) Separation from mother: Danny was allowed to earn a phone call home. This was very reinforcing to him during the first week in residence. However, he gradually lost interest. During this time, Danny was allowed to realize much of his own potential, proving to himself that he was, in fact, able to be quite independent. This new found sense of self-worth and accomplishment would seem to be more reinforcing than the dependency upon his mother.

2,3) Washing hair and taking showers: (a) During the first week, Danny's washing-up consisted of washing his face, neck, and hands with a wash cloth. (b) During the second week, Danny watched other residents wash cars and play with the hose. He also was allowed to play in a wading pool, then later taken to the beach to play at the ocean's edge. He was also given a squirt

gun for free-time play. (c) During the third week, he was shown a sequential arrangement of pictures depicting water scenes while he was enjoying his meals. (d) During the fourth week, Danny was allowed to turn on his own shower to a force he felt comfortable with, and gradually asked to increase this. Danny earned snack during this week for taking a good shower. The snack was phased out during the fifth week when he was quite proud of being able to take his own shower and wash his hair without any help.

Danny had a chronic ear infection that apparently caused him great pain when he got water in his ears. This association of pain with water, in any context, may well have precipitated his avoidance reactions to water in general.

4,6) Physical examination: Modeling was used very successfully for treatment in this area as Danny has frequent need to use ear drops. Another resident showed Danny how he had learned to put ear drops in all by himself,. Danny then allowed another resident to administer the drops to his ears. The next day, he did it with the help of another staff member until gradually he could put his ear drops in with only a minimum of supervision.

5) Eating with a group of children: Danny showed no fears or acting out at mealtime. This might have possibly been due to the point system in effect at mealtime.

Behavior often exhibited were tantrums and destructive behavior. At this time, Danny would often pretend he was a monster and make bizarre animal noises. At times, he also behaved as if he were the Bionic Man or a super powerful being. In order to reduce this fantasizing, the following treatment was begun July 19, 1976:

1) ignore fantasy verbalization
2) refocus conversation away from fantasy
3) praise his talking about "real" people, activities, etc.
4) praise his engaging in activities, such as softball, playing with other children
5) control his environment to reduce exposure to fantasy animals and people on television (i.e., the Bionic Man), and in books, etc.

On the other hand, he sometimes behaved in an extremely dependent fashion (i.e., whinning and other infantile behaviors). To increase his self-esteem and independence, the following treatment was devised:

1) ignore references to himself as being a baby, weak, out-of-control, etc.
2) refer to Danny as a "big boy," "strong," etc., in a realistic context
3) use his art work ability (not monsters or dinosaurs) to channel his activity as well as class work
4) encourage athletic activities so he can feel his physical control over himself

To reduce general anxiety, the following biofeedback treatment was used:

> Muscle relaxation procedure (Cybord Corporation, 1975) introduced to him and his parents. His anxiety reduction can be influenced by the other therapeutically conducive interventions surrounding him at the residency and at home as well.
>
> His muscle tension was measured by EMG biofeedback machine and muscle relaxation training was administered. The results of this treatment are shown here.

Danny's EMG Readings

Date	EMG Reading in Unit Volts (uV)	Mean uV
7/12/76 (pre-measure)	52 uV-151 uV	52 uV
8/30/76 (post-measure)	5.3 uV-19.1 uV	10.3 uV

The above data indicated that Danny was extremely tense on the pre-measures, but was quite relaxed on the post-measures.

Readings below 4. uV indicate a remarkably relaxed state. Increased readings indicate greater degrees of muscle tension. The maximum reading on our equipment is 250 unit volts.

Self Concept

The Piers Harris Children's Self Concept Scale (The Way I Feel About Myself) was given to Danny upon entering residency on July 7, 1976, and again on September 1, 1976, when leaving residency. Pre and post tests were administered to determine any growth in self-concept after Pendleton Project residential treatment. Scores are shown below:

	Raw Score	Percentile
Pre-test	28	6
Post-test	63	77

Average scores are considered to be those between the 31st and 70th percentile or between the raw scores of 46 to 60. Danny's pre-test score fell far below the average range. The greatest areas of growth were seen in Danny's Intellectual and School Status and Popularity subscales.

According to the diagnosis by psychiatrist Dr. Dowling and a clinical psychologist, Dr. Volenski, Danny appeared to be an extremely anxious, fearful, and self-stimulating child. For example, yelling for no apparent reason, making animal sounds, making monster noises and movements, cursing to himself, and nasty gestures were observed during the initial two to three weeks of his residency at the Pendleton Project.

Two behaviors that were treated were considered to be representative of the progress made in Danny's case. These behaviors are backtalking and cussing. Although these behaviors are not eminently serious or dangerous ones, they did precipitate

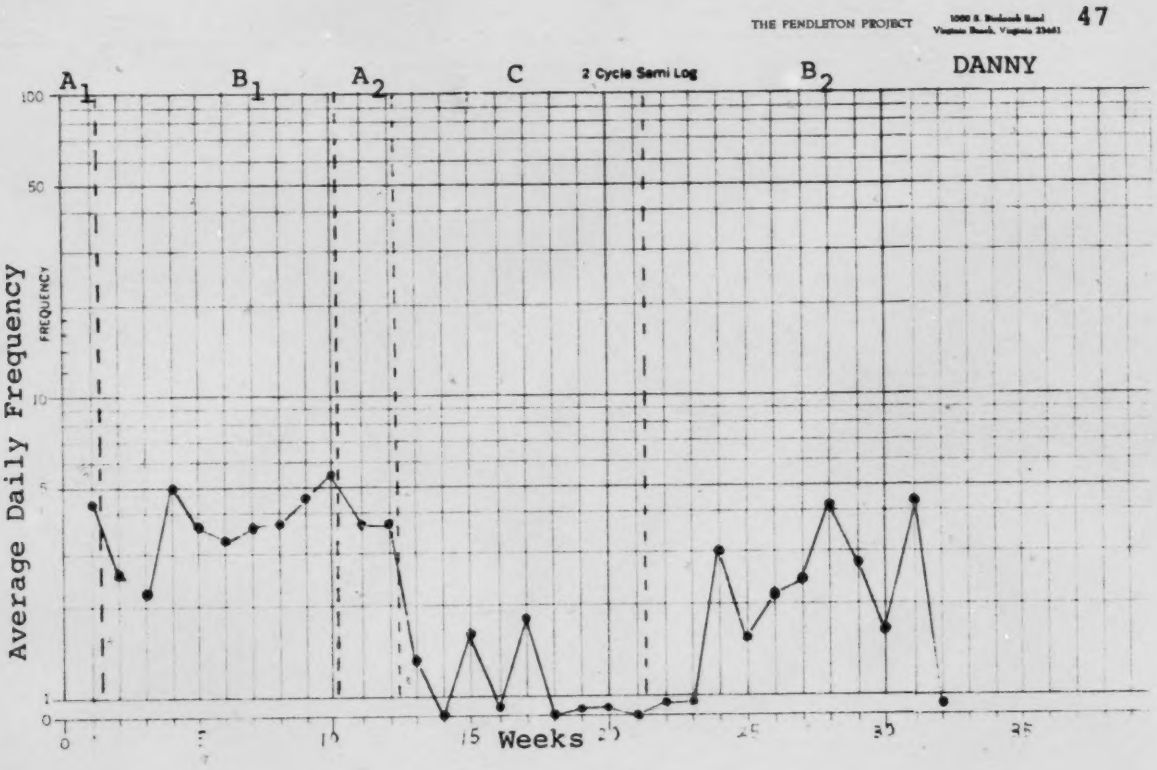


FIGURE II-10

Rate of Backtalking Per Day During Each Week

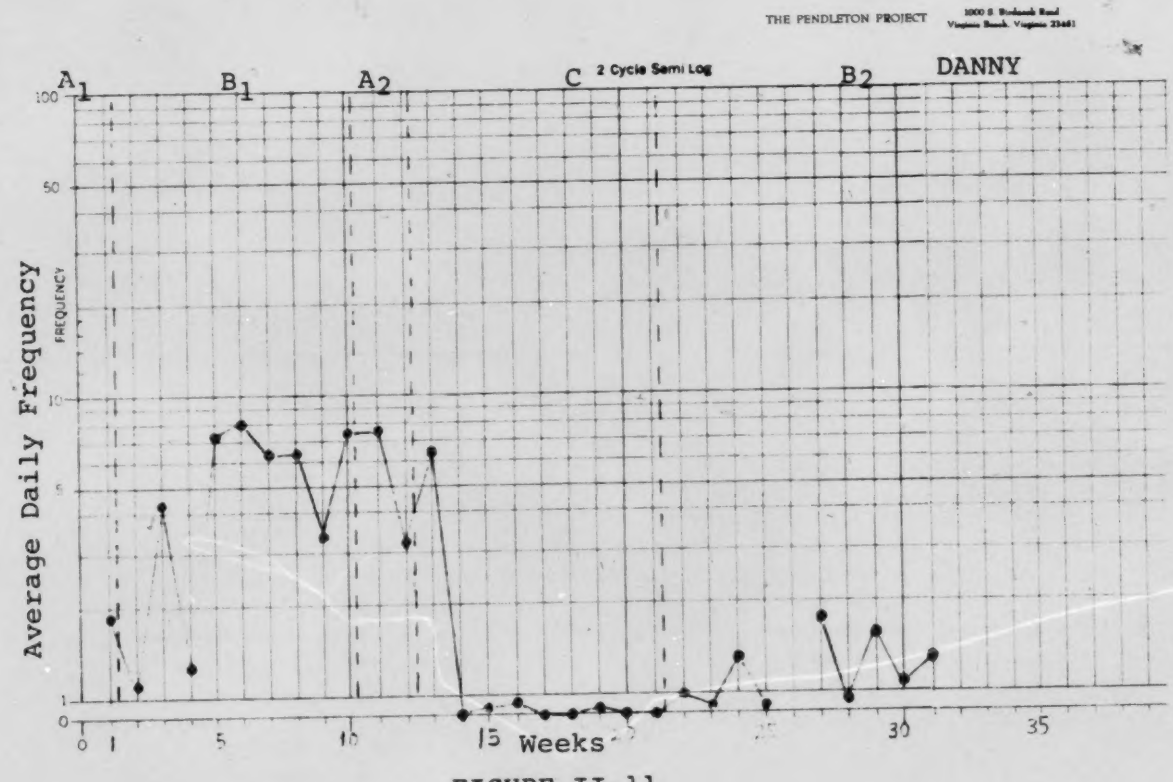


FIGURE II-11

Rate of Cussing Per Day During Each Week

frequent undesirable responses on the part of others which may have served to maintain Danny's problem behaviors.

As shown in Figure II-10 and Figure II-11, target behaviors, such as backtalking and cussing decreased from the baseline phases (A_1 and A_2) to intervention phases (B_1, C, and B_2) as follows:

Treatment Phases	Average Target Behavior Frequencies/Day	
	Backtalking	Cussing
A_1 (Outclient baseline)	4.4	1.9
B_1 (Outclient treatment)	3.8	5.0
A_2 (Residential baseline)	3.8	5.3
C (Residential treatment)	0.6	0.8
B_2 (Outclient treatment)	2.2	1.0

However, these target behaviors didn't seem to be under his control after he was mainstreamed to his family and his public school (i.e., C=0.6 + 0.8, whereas, B_2=2.2 and 1.0). This is not unusual phenomena, rather it demonstrates the difficulty of attempting to generalize behaviors that were brought under control in a structured setting to the natural environment.

In order to maintain the low rate of the above and other target behaviors, the following recommendations were made upon his discharge from residential treatment.

Recommendations:

Home

1) Encourage Danny's grown-up behavior.
2) Ignore artificial pleas for help.
3) Ignore verbalizations of fears; instead, praise other models for their grown-up behavior.
4) Encourage Danny to take responsibility upon himself.
5) Give Danny directions in a clear, firm, voice. If in doubt of his comprehension, ask him to repeat the directions to you before execution.

School

1) Placement in a E. D. classroom.
2) Remediate pin-pointed academic deficits.
3) Utilize instructions on an individual basis or a very small group.
4) Clarify and be explicit in task instructions.
5) Frequently reward task performance.
6) Present tasks in a step-wise fashion.

Post-residence Outclient Treatment

During the eleven weeks (to date of this writing) following Danny's residential treatment, a home program using happy faces associated with verbal praise by parents has been used. Time out on a chair is implemented when necessary. The Center for Effective Learning, Danny's E. D. placement, has a token economy. Danny brings a note home daily regarding his behavior. If the note is good, he is rewarded with a snack after school and verbal praise. In addition, the parents are recording (self-monitoring) each time they punish, reward, and spank Danny. The goal is to increase a positive relationship between Danny and his parents since he responds more appropriately, in general, to a positive environment.

At present, Danny's behavioral and academic performance at the Center for Effective Learning (C.E.L.) is very good. According to the teacher, he is performing and improving at an adequate rate. Danny's behavior is maintained at home under a highly structured program. Many of his behavioral problems have come under self-control. At present, the most outstanding difficulty is his overactivity which manifests itself in several behavioral problems. We are continuing to work with Danny and his family on a weekly outclient basis. It is anticipated that this work will continue until the inappropriate behaviors are

replaced by acceptable acts in a stable manner. Danny will attend C.E.L. indefinitely. It is also anticipated that Danny will always be an anxious person, but he appears to have the intellectual ability to compensate and redirect his anxiety in constructive ways.

Summer Day Care Program Evaluation

During the summer of 1976, July 7 to August 25, a day care program was initiated at the Pendleton Project in order to meet two major needs of the community and the project: (1) to provide a structured program which emphasized social skill development, academic achievement, and physical education skills for those children referred to the project who were experiencing relatively mild behavioral difficulties in the home, school, and community; (2) to provide an intermediate level, transitional stage for phasing children out of the residential program into the natural environment.

Population. The following statistics were complied on those children involved in the day care program during the summer of 1976:

Referrals: N=31

Sex: Females = 8. Males = 23

City of referral: Chesapeake - 10
Virginia Beach - 21

Duration of treatment in day care: Mean = 10 days
Range = 3-20 days

Treatment Outcome. The effectiveness of the day care treatment program was assessed on August 26, 1976, according to the following criteria:

A. Analysis of target behavior data while in day care.
B. Analysis of academic performance while in day care.
C. Day care advocates clinical impression of the child's progress.

This evaluation procedure yielded the following results:

Positive impact on student - 55% (N=17)
Insignificant impact - 41% (N=13)
Undetermined impact - 3% (N=1)

The preliminary evaluation of the day care program suggests the following:

1) That it is very difficult to give either the day care or residential children the high quality, intensive treatment necessary when the number of children served by the residential team is in the range of 20-25 students. Both the behavioral management and academic programs designed for the individual student seemed to be adversely affected by the large number of children who were involved in the day care and residential programs this summer. Specific advantages and disadvantages of the program assessed by the residential treatment staff are outlined below.

Disadvantages

1) Bussing of children from two central locations in Chesapeake involved approximately four hours of staff time daily.

2) Individual academic achievement testing of students was difficult.

3) Individualized academic programs for each child were difficult to design.

4) The dimensions of the current classroom are too small for 20-25 students.

5) One-to-one counseling of students was limited due to the large number.

6) Parents consistency in following through on the recommendations by the treatment was a recurrent problem.

Advantages

1) A large number of students may be treated which eliminates the need for a "waiting list."

2) A larger number of students became aware of their difficulties and learned new coping skills in a short period of time.

3) The Pendleton class more closely simulated the public school classroom in terms of numbers of students.

4) Females were introduced into the residential classroom which provided an experimental setting for co-educational treatment.

5) The structured summer program met a community need and was good public relations for the project.

The evaluation was a preliminary assessment of the day care program. A more thorough assessment will be done in order to compare the success rate of day care children versus those children who received only outclient treatment or residential and outclient treatment.

CHAPTER III

OBJECTIVE III: TO DEVELOP NEW RESOURCES AND COORDINATE EXISTING RESOURCES

Summary

Efforts to develop and coordinate resources are a continuing task of the Pendleton Project. The direct service distribution is shown in Table III-1 by referral source. Some cases are referred to other agencies to avoid duplication of services or are treated by Pendleton in concert with one or more other agencies. These data are presented in Table III-2. In order to continually upgrade staff competence, the project takes advantage of training opportunities whenever possible. These activities for this report period are presented in Table III-3. The project also answers requests to do training for other agencies and to make presentations at professional meetings. In Table III-4, these activities are summarized.

Formal training relationships have been established with several area universities. These efforts take the form of classroom instruction to graduate and undergraduate students together with the supervision of student placements for internships, research papers, and volunteer work. During this report period and during several days of the preceeding report period, a university course was taught by three members of the Pendleton staff (Dr. R. C. Pooley, Dr. R. J. Shea, Dr. B. Eun). The course is titled *Motivation Management in the School and Home, EFSMI-497* (three credits), Old Dominion University Extension

Services. This was the third time the course was offered. The students consisted of fourteen members of the Chesapeake Alternative School staff and one Pendleton employee - all graduate students. The Chesapeake Alternative School is a special school within the public school system designed to administer education to youths 12 to 18 years of age who exhibit behavior and/or learning problems.

In a separate effort, in-service training was provided at the request of the Chesapeake Social Service Bureau. Fifteen social services workers attended a series of training seminars provided by five members of the Pendleton staff (Pooley, Shea, Rice, Bloomer, and Eun).

TABLE III-1 REFERRAL SOURCE

Referral Source	Frequency	CF	%	CP
1. Chesapeake Schools	137	137	18.1	18.1
2. Ches. Social Services	47	184	6.2	24.3
3. Ches. Juvenile Court	44	228	5.8	30.1
4. Ches. Public Health	5	601	0.6	30.7
5. Ches. Youth Bureau	2	230	0.2	30.9
6. Ches. Devel. Workshop	1	231	0.1	31.0
7. Chesapeake Parents	44	275	5.8	36.8
8. Va. Beach Schools	164	439	21.6	58.4
9. Va. Beach Social Services	43	482	5.6	64.0
10. Va. Beach Juvenile Court	47	529	6.2	70.2
11. Va. Beach Comp. Mental Health	24	553	3.2	73.4
12. Va. Beach Public Health	4	557	0.5	73.9
13. Va. Beach Parents	144	701	19.7	93.6
14. Citizen	6	563	0.7	94.3
15. Private Agency	33	596	4.3	98.6
16. Other	11	756	1.4	100.0

Referrals from parents in both cities have been increasing as a result of public relations efforts. The schools continue to be a frequent source of referral, and there is a steady flow of referrals from both public and private human service agencies.

CF = Cumulative Frequency

CP = Cumulative Percent

TABLE III-2 AGENCIES REFERRED TO

Agencies Referred to	Partial* F	%	CF	CP	Total** F	%	CF	CP
1. Ches. School	2	.7	2	.7	1	2.4	1	2.4
2. Ches. Soc. Serv.	14	4.7	16	5.4	5	12.2	6	14.6
3. Ches. Juv. Court	0	0	16	5.4	0		6	14.6
4. Ches. Youth Bur.	0	0	16	5.4	1	2.4	7	17.0
5. Ches. Devel. Workshop	0	0	16	5.4	0		7	17.0
6. Va. Beach Schools	10	3.3	26	8.7	0		7	17.0
7. Va. Beach Dept. of Soc. Service	17	5.7	43	14.4	11	26.8	18	43.8
8. Va. Beach Juv. Ct.	4	1.3	47	15.7	0		18	43.8
9. Va. Beach Comp. Mental Health	20	6.7	67	22.4	9	22.0	27	65.8
10. Public Health	37	12.4	104	34.8	0		27	65.8
11. Tidewater Rehab. Institute	2	.7	106	35.5	0		27	65.8
12. Private Psychiatrist	11	3.7	117	39.2	0		27	65.8
13. Neurologist	2	.7	119	39.9	0		27	65.8
14. Priv. Psychologist	3	1.0	122	40.9	1	2.4	28	68.2
15. Priv. Physician	71	23.7	193	64.6	0		28	68.2
16. Norfolk & Ches. Comm. Mental Health	1	.3	194	64.9	0		28	68.2
17. Residential (non Pendleton)	1	.3	195	65.2	2	4.9	30	73.1
18. Family Service/ Travelers Aid	14	4.7	209	69.9	2	4.9	32	78.0
19. Dental	66	22.1	275	92.0	0		32	78.0
20. Other	24	8.0	299	100.0	9	22.0	41	100.0

Partial N = 299
% = 36
Range 0-71

Total N = 41
% = 6
Range 0-11

* A partial referral to another agency is defined as a case being referred for a selected service (e.g., foster home placement) while Pendleton continues to work on the problem behaviors.

** A total referral to another agency is defined as a case being referred entirely to another resource for more appropriate services (e.g., family counseling).

Table III-2 indicates 36% of cases were referred to other agencies for a selected service while Pendleton continued to work on the problem behaviors; 6% of the cases were referred to other resources for more appropriate services. This data indicates one effort to foster inter-agency cooperation in the delivery of services to the target population.

TABLE III-3 TRAINING RECEIVED

The following training was received by various staff members since July, 1976.

Date	Title and Sponsoring Agency	Staff
7/10-12/30	Virginia Commonwealth University Rehabilitation Counseling - 18 graduate hours	Lee
7/22-23	Intergovernmental Coordination Conference, Norfolk	Pooley Davidson
8/9-10	Fund Raising Conference, University of Chicago	Davidson
8/31-9/1,2	New Teachers' Meeting, Virginia Beach	Mooney
9/2	Assertiveness Training Workshop Washington, D. C.	DeCaro
9/3,7	American Psychological Association Annual Convention, Washington, D.C.	Eun, Lee, DeCaro
9/14-12/14	Ten-week Group Leadership Training. Family Service Travelers' Aide	Wheeler Rice
9/16	Comprehensive Drug and Alcohol Program. Mental Health/Mental Retardation Services Board, VB	Shea Chapin
9/23-12/3	B.S.Candidate-Elementary Education, Tidewater Community College, 12 credit hours	DeCaro
9/30	Symposium on Health Care for the Poor. Eastern Virginia Medical School	Davidson Walker
10/2	Family Systems Therapy, Tidewater Psychiatric Institute	DeCaro
10/6,8	Project Management Seminar U. S. Civil Service Commission	Davidson
10/19	Seminar: Child Abuse. Eastern Virginia Medical School, Department of Psychiatry	Pooley

Table III-3 Training Received continued

Date	Title and Sponsoring Agency	Staff
10/23	Conference on Exceptionality - Learning Disabilities, Old Dominion University	Mooney, DeCaro
11/12	"Psychiatric Illnesses in Children" - Eastern Virginia Medical School, Department of Psychiatry and Behavioral Sciences seminar	Pooley, Shea, Eun
11/12	Working with deaf children given by Mrs. Berry, teacher of the hearing impaired	Bloomer, Nichols, Paganelli
12/1	Eastern Virginia Medical School seminar. "Computers Can Help Clinical, Administrative, and Research Uses."	Pooley Davidson
11/17, 18, 19	Virginia Council on Social Welfare, Eastern Conference, Virginia Beach	Pooley, Shea, Eun, DeCaro, Davidson, Rice, Ackerman, Spinelli, Ruttenberg, Wheeler
12/1	Regional Volunteer Coordinators Training	Chapin
12/1	Training conference regarding deaf child in residence	Beckett Andrews

TABLE III-4 PRESENTATIONS

The following presentations were given by the staff to various individuals and groups since July, 1976.

Date	Presentation to	Size of Audience	Staff	Time
7/1	Middle Childhood Class Old Dominion University	11	M.Johnson	1 hour
7/1	Norfolk State Class	15	M.Johnson	1 hour
7/1	Optimist Club of VB	25	Chapin	1½ hours
7/2,9 16,30	Chesapeake Public Health In-service Training	15	Pooley, Rice,Prizzio, Shea, Bloomer, Walker	6 hours
7/9	Pendleton Project In-service Assertiveness Training	12	DeCaro	1 hour
7/28	Community Consultiin Services, Dr. Craven	1	Prizzio, Mooney, Chapin	1½ hours
7/28	Norfolk Girls' Group Home	2	M.Johnson	3 hours
7/29	VB, Chesapeake Elementary School Principals	8	Pooley, Shea Eun, Bloomer, Mooney, Johnson	2 hours
6/15,17 22,25, 8/3,5, 10,12, 17,19	Chesapeake Alternative School EFSMI-497, ODU Extension Course	15	Pooley, Eun, Shea	32 hours
9/3	Thalia Elementary School, VB	4	Prizzio	1½ hours
9/7,8,9	Girls' Group Home, Norfolk		M.Johnson	3 days
9/14,15	Regional Training for Probation Officers	13	Chapin	11 hours
9/29	WVEC-TV Midday Show		Shea	10 min.
9/30	Dr. Thomas Curran, Chief Psychologist, VB	1	Shea, Mooney	2 hours

TABLE III-4 Presentations continued

Date	Presentation to	Size of Audience	Staff	Time
10/4	Laura Hays/John Davidson Show, WVEC Radio		Shea Davidson	30 min.
10/4	Comprehensive Mental Health Services, VB, Children's Unit	4	Shea	45 min.
10/6	Cooke Elementary, VB Principal, Assistant Principal	2	Chapin	30 min.
10/7	Trantwood Elementary, VB Principal, Assistant Principal	2	Chapin	30 min.
10/7	Seatack Elementary, VB Principal, Assistant Principal	2	Chapin	30 min.
10/12	Kingston Elementary, VB Principal, Assistant Principal	2	Chapin	30 min.
10/13	Linkhorn Elementary, VB Principal, Assistant Principal	2	Chapin	30 min.
10/13	Malibu Elementary, VB Principal, Assistant Principal	2	Chapin	30 min.
10/14	Diversion Unit, Chesapeake	15	Prizzio	3½ hours
10/14	Kings Grant Elementary, VB Principal, Assistant Principal	2	Chapin	30 min.
10/14	Holland Elementary, VB Principal, Assistant Principal	2	Chapin	30 min.
10/18	International Association of Pupil Personnel Workers Annual Conference, Norfolk, Va.	40	Pooley, Shea, Eun, Bloomer, Mooney	2 hours
10/19	Norfolk State College Sociology Class	15	Rice	3 hours
10/28	WTAR (Radio and TV) Community Needs Luncheon		Shea	1 hour
11/8	Holland Elementary Faculty	37	Chapin	30 min.
11/9	Chesapeake Boys' Group Home staff	5	Chapin	1 hour
11/9	Chesapeake Group Home	5	Beasley	1½ hours
11/10, 17 & 12/1,8	Chesapeake Social Services Bureau, In-service Training	15	Pooley, Eun Bloomer, Shea, Rice	4 hours

TABLE III-4 Presentations continued

Date	Presentation to	Size of Audience	Staff	Time
11/10	State Commissioners of Human Services & Education		Pooley, Shea Eun, Johnson, Chapin, Rice, Bloomer, Walker, Beckett, Lee, Ackerman, Davidson	2½ hours
10/19	Norfolk State College, Sociology Class	15	Rice	3 hours
11/11	Graduate Students	2	Bloomer	2 hours
11/12	Community/Clinical Graduate Psychiatric Program, Norfolk State College	3	Shea, Eun	1 hour
11/16	Sociology Class, Old Dominion University	10	Prizzio Ackerman Eun	2 hours
11/17	Human Resources Institute	3	Pooley, Eun, Lee	2½ hours
11/18	Virginia Council on Social Welfare, Eastern Conference, Virginia Beach	80	Chapin	1½ hours
11/29	Commissioner Lukhard and Commissioner Dickerson	2	Pooley, Davidson, Shea, Eun, Bloomer, Rice	2 hours
11/29	Principal & Director, School for Deaf, Hampton	2	Bloomer	2 hours
11/29, 30	Mental Health Class, Tidewater Community College	4	Prizzio Rowlands, Mooney	1½ hours
11/30	In-service training to residential unit regarding deaf child in residence	8	Nichols, Paganelli	1½ hours
12/1	Chesapeake Social Workers	18	Bloomer	1 hour
12/2	Red Cross Parents' Group		Rice	2 hours
12/3	Pediatricians: Drs. Thomas Mosby, Grey, and nurses	5	Pooley, Eun Shea, Prizzio, Walker	1½ hours

Exemplary Project Status

On July 18, 1975, Edward Sikora, LEAA Regional Office, U. S. Department of Justice, Philadelphia, visited the Pendleton Project. As a result of this visit, Mr. Sikora recommended that it may be appropriate to submit an application for Exemplary Project Status. Accordingly, the required forms were completed and submitted on September 19, 1975, to the Division of Justice and Crime Prevention (DJCP), Richmond, together with copies of our semi-annual reports and grant applications. The material was reviewed by DJCP and forwarded to the Office of Technology Transfer, Model Program Development Divison, National Institute of Law Enforcement and Criminal Justice, U. S. Department of Justice. On October 24, Dr. Richard Pooley, project director, received a phone call from Robert Askeroff of the Office of Technology Transfer. A follow-up letter was received from Mr. Aserkoff on October 31, 1975 (see *Semi-Annual Report, January, 1976*). Mr. Aserkoff had done a preliminary review of our Exemplary Project application and had asked for more detailed information prior to further consideration of the application.

In answer to this request, a thirty-four page special report (Pooley, Shea, Eun, 1976) was prepared by the Pendleton Project and submitted to Mr. Aserkoff on February 20, 1976. We were confident that the special report would answer any remaining questions that the Office of Technology Transfer might raise.

The answer we received for that effort is documented in Mr. Askeroff's letter of April 23, 1976 (see *Semi-Annual Report, July, 1976).* The essence of the letter is summarized in Mr. Aserkoff's closing statement on the subject.

> "While these results are important and worthy of emulation, the link between such measures and the justice-system outcomes remains more a conjectural one than a conclusion of any real empirical research. It, therefore, seems that although the concept of the Pendleton Project is a sound one, the long-term nature of its anticipated effects and the evident difficulty of gathering data with which to validate the effects preclude its further consideration as a candidate for exemplary status."

We, at the project, strongly believe that we do qualify for exemplary status. Accordingly, one more attempt was made to reopen our bid in this regard. The correspondence stating our case together with Mr. Askeroff's answer of November 4, 1976, is included here. In view of this steadfast resistance to reconsider our application for exemplary status, the project has decided not to pursue the matter any further.

the pendleton project
1000 South Birdneck Rd., Virginia Beach, Va. 23451 Phone 804 425-6692

September 2, 1976

Mr. Robert Aserkoff
United States Department of Justice
Law Enforcement Assistance Administration
Office of Technology Transfer
National Institute of Law Enforcement and Criminal Justice
Washington, D.C. 20531

Dear Mr. Aserkoff:

This is in reference to the application for exemplary status submitted by the Pendleton Project in October, 1975. The last correspondence on this matter was your letter of April 23, 1976 to me.

Your letter was reviewed during a management board meeting and the decision was reached to supply you with additional data when it became available. Accordingly, I am enclosing a copy of our most recent semiannual report (July, 1976).

During the discussion of your letter in the management board meeting, a member of the board asked me exactly what is the criterion that a Project must reach in order to attain exemplary status. I had no answer to this question.

It occurred to me that perhaps I should study the matter in more detail. While doing this I came across an article that probably explains perceptions concerning the project that may have contributed to having our application for exemplary status placed in abeyance. The article also suggested steps to remedy the situation. Perhaps these steps will serve as a criterion to evaluate our project.

In her article "Alternative Models of Program Evaluation", Social Work, November, 1974, Carol H. Weiss describes the quandary we are in. She states that . . . "Long periods can elapse before results become available for decisional purposes . . . or those initiating a new program may have such strong reformist zeal that they use premature data in an attempt to push the program through."

Her recommendations for evaluation of time-bound projects such as ours are given in six prerequisite steps.

"1. Examine the nature of the social problem and explore its dynamics.
2. Hypothesize, or better yet, understand the causal linkages.
3. Identify effective points of intervention.
4. Indicate the likelihood that intervention will be successful.
5. Examine the political context for supporting and sustaining the intervention and make sure it is appropriate.
6. Show that the benefits and the ways they are to be distributed are likely to warrent the social cost of the experiment.

At this juncture, when a specific new social initiative has been identified and has sufficient credibility for policy-makers to consider it, social experimentation provides an elegant data base for decision-making. It can produce kinds of information that prevent costly national failures and lead to better informed and more successful choices at the policy level."

I submit to you that the Pendleton Project has advanced through all six steps with considerable evidence to support the criterion stated in step number six.

Apparently the criterion expected by your office for consideration as an exemplary project is longitudinal in nature. In order for our Project to generate these kinds of data we must stay in business for at least 3 more years. In order to do that we must maintain the social and political interest and support we have enjoyed to date. This is necessary in order to increase the probability of future funding from sources other than LEAA. Exemplary Project status can definitely serve this objective. Furthermore, we sincerely believe we have earned such status. In this regard I call your attention to the research studies reported in Chapter IV of the enclosed report (July, 1976). The research procedures reported here are certainly adequate for time-bound investigations. Furthermore, I call your attention to the public interest generated by the Project's activities (pp. 26 - 28). Fifty-one agencies from 29 states have requested information concerning our methods. I believe we have a responsibility to the people to provide accurate information. This requires replication and refinement of procedures over time.

In view of these things we request that our exemplary project status application be re-examined in the light of materials previously submitted and the report enclosed here.

Sincerely,

Richard C Pooley

Richard C. Pooley, Ph.D.
Director

cc: Virginia SPA
Regional Office III

UNITED STATES DEPARTMENT OF JUSTICE
LAW ENFORCEMENT ASSISTANCE ADMINISTRATION
WASHINGTON, D. C. 20531

NATIONAL INSTITUTE OF LAW ENFORCEMENT
AND CRIMINAL JUSTICE

November 4, 1976

Mr. Richard C. Pooley, Ph.D.
Director
The Pendleton Project
1000 S. Birdneck Road
Virginia Beach, Virginia 23451

Dear Dr. Pooley:

The National Institute has concluded its review of the materials of the Pendleton Project submitted for consideration as an Exemplary Project. These materials were also carefully reviewed by staff of the Office of Juvenile Justice and Delinquency Prevention, whose views and conclusions are represented herein.

Let me first address your questions about the Exemplary Projects selection criteria which you mention in the correspondence that accompanied your Semi-Annual Report. As indicated in the enclosed brochure, these selection criteria include goal achievement, measurability, cost efficiency, and replicability. Above all else, Exemplary Projects are action programs which, through their own evaluation, have proven themselves to be notably more successful than similar programs in reducing crime and/or improving the quality and administration of justice. These are programs which the Exemplary Projects Review Board deems worthy of nationwide recognition and implementation.

For the following reasons, we are unable to give the Pendleton Project further consideration as an Exemplary Project. Our conclusions relate to the evaluation methodology and the resultant conclusions within the context of a prevention/diversion treatment program, dealing with pre-delinquent and delinquent children.

While data presented in the Semi-Annual Report indicate a high degree of success, the evaluation techniques appear very subjective and therefore inconclusive. Successful termination is defined as the diagnostic opinion or perception of the Pendleton treatment agent, teacher and/or parent that the child is "functioning acceptably". The data only serve to confirm this concern since

only one child out of 322 cases is identified as having been afforded treatment that was unsuccessful. Given the nature of your program and its clientele, this extraordinarily high success rate appears open to challenge. Furthermore, it is very difficult to determine whether changes that might be perceived in a child's behavior are due to the program's intervention or to some other influence such as maturation, peer or family influences, etc.

Our further concerns go to the evaluation of the treatment services themselves. Observations of incidents of targeted behaviors were made and recorded by parents and teachers. Particularly for rather broadly defined behaviors such as temper tantrums, fighting, and disobedience, it would seem very difficult for an observer (parent or teacher) to determine whether the observed behavior was child or peer initiated, and to account for the interactive context of the behavior. Particularly in the classroom, this type of observation would seem to be influenced by teacher attitudes, class size, and the overall class behavior pattern.

In addition to inconclusive information about program effectiveness, some of the procedures of the program seem rather questionable. The clientele range from six to twelve years old, the lower range of which is indeed a very young age to be identified as a potential delinquent. Moreover, it appears that a juvenile may be referred to the program on the recommendation of a teacher, who is very likely influenced by personal attitudes, total classroom environment, etc. This becomes a serious problem in that little consideration seems to be given to the potential negative effects of labeling these young children as potential delinquents.

Please by assured that these comments are not intended as criticisms of the program or its goals, but rather are problematic issues that are left unresolved without conclusive evaluative data. As I stated in my most recent correspondence to you, the Pendleton Project appears to offer many worthwhile services to children in need of rehabilitative attention. We want to wish your staff and clients well in the pursuit of these goals.

Respectfully,

Robert Aserkoff
Office of Technolgy Transfer

cc: RO III
Va. SPA

International and National Dissemination of Information

During this report period, the project has received recognition in two international arenas. The project was invited to present a symposium titled *An Experiment in Creative Problem Solving* (Pooley, 1976) at the International Association of Pupil Personnel Workers Annual Conference, October 17-21, 1976, sponsored by the Tidewater Visiting Teacher Association. The symposium was presented on October 18 in Norfolk, Virginia. It was two hours in length and was attended by about 50 persons.

A description of the Pendleton Project together with reference for additional information was included in *Guide to Productivity Improvement Projects*, 3rd edition. This book is prepared annually by the International City Management Association for the National Center for Productivity and Quality of Working Life.

Several documents produced by the project have been accepted and included in the Educational Resources Information Center (ERIC). These publications consist of selected semi-annual reports and papers that were written by the project staff in the recent past. The ERIC system is a federally-funded nationwide information system designed to serve the field of education through the dissemination of unpublished resources and research materials. This system will help meet the needs of those interested in our project. In the past year, we have received requests for information from 64 localities in 31 states, and a request from two Canadian provinces (see *Semi-Annual*

Report, July, 1976). In the past six months, we have received requests from the agencies listed here:

California

Ms. Betty M. LaBrie
Project Director
Sentencing Alternatives Program, Voluntary Action Center
San Jose

Ms. Thomatra N. Scott
Youth Program Specialist
Young Adults, Inc.
San Francisco

Connecticut

Mrs. Claire Gallant
Consultant, School of Social Work
Bureau of Pupil Personnel & Special Education Services
Hartford

Mr. John J. Raymond
Youth Coordination
Town of East Hampton

Georgia

Dr. Paul B. Wilson
Coordinator, Criminal Justice Program
Valdosta State College

Illinois

Mr. Andrew Gordon
Associate Professor
Sociology, Psychology & Urban Affairs
Northwestern University
Evanston

Indiana

Mr. Dick Bowen
Human Resources Department
Municipal Building
Bloomington

Massachusetts

Professor Sanford J. Fox
Boston College Law School
Newton Centre

Ohio

Steve M. Neuhaus, Ph.D.
Program Coordinator
Portage County Cooperative Learning Program
Kent State University

Virginia

State Crime Commission
Richmond

Mr. Keith Zirkle
Intake & Admissions Counselor
Commonwealth Psychiatric Center
Richmond

Washington

Mr. George Guttman, Director
Division of Youth Affairs
Dept. of Planning & Community Development
King County Administration Bldg.
Seattle

Wisconsin

Mr. Tom Fisher
Madison

Canada

Miss Mindy Coplevitch
School Social Worker
The Protestant School Board of Greater Montreal

Ms. Linda Phillips
Program Development Assist
Ministry of Corrective & Rehabilitative Services
Legislative Building
Winnipeg

Volunteer Program

The program, Volunteers for Pendleton, has included twelve volunteers and one volunteer coordinator since July, 1976. Volunteer applicants are screened and oriented to the project prior to being given an assignment. They are required to spend three hours per week at their jobs, three hours per month doing public relations for Pendleton is requested, and two hours per month of supervision by project staff is scheduled. Volunteers must make a committment of six months at minimum.

Since July, 1976, a total of 279½ hours were spent by volunteers working for Pendleton. The following is a list of activities and hours spent on each activity.

Child Advocate (Big Brother or Sister)	130 1/2 hours
Tutor	49 3/4 hours
Orientation	8 3/4 hours
Supervision	20 hours
Public Relations	4 hours
Leading Classes	33 1/2 hours
Working with Parents	1 hour
Observation of Pendleton staff	18 3/4 hours

CHAPTER IV

OBJECTIVE IV: TO MEASURE THE EFFECTIVENESS OF THE WORK

Summary

The Pendleton Project has developed a variety of methods to measure the effectiveness of the work. First, among these, is a ratio that is calculated based on the status of terminated cases. Table IV-1 shows the categories of terminations and the number of terminations within each category. The numerator of the ratio is the number of category A terminations which indicates successful behavioral change. The denominator of the ratio is all other categories of termination. The product of this ratio indicates a success figure in percent. Similar calculations are made during the follow-up procedure with one modification. The numerator of the follow-up data includes the number of children in follow-up code "A" (i.e., child continues to function adequately) plus those children who are identified as follow-up code "O" (i.e., child has regressed, but behavior is still tolerable). The results of these calculations are presented in detail for the total program and for each sequence of treatment alternatives. Follow-up success rates are reported as well.

To summarize these dates as of this report period, the project has received 753 referrals and has terminated 653 of them. At termination, 76% of the children were successfully treated.

The enduring effects of treatment are largely dependent on the degree to which those in the child's natural environment (i.e., teachers and parents) follow through with our recommendations. In spite of this limitation, follow-up investigations reveal some promising characteristics. Two years after treatment, 42% of the children served are functioning at an acceptable level - that is, 42% of the worst behavior problem children in the two-city area that have been identified and referred to us for treatment.

SUMMARY OF TREATMENT EFFECTIVENESS

	Children Functioning Acceptably at Follow-up Contacts:			
Successful Terminations	1 month	5 months	12 months	24 months
76%	68%	59%	58%	42%

As a result of follow-up contacts and direct referrals, 79 cases (12%) have been reopened for additional services. This low rate of repeaters, together with the follow-up data presented above, suggest that the treatment procedures employed at Pendleton are effective and enduring for at least one year after treatment in most cases.

A second method to measure effectiveness is to have the project evaluated by an unbiased outside agency. It is timely to have such an evaluation conducted during the third year of a new organization such as the Pendleton Project. Accordingly, the Touche Ross Public Accounting and Business Management firm was contracted for this purpose. The results of their evaluation is discussed in detail in this chapter. Sixteen project

goals were distilled from the final report of the Touche Ross investigation. The strategy for attaining these goals is also described together with a two-year plan of action for FY 77-78 and FY 78-79.

Termination and Follow-Up

A treatment program is considered successful if the objectives determined jointly by the Pendleton treatment agent and the parent and/or teacher are met such that (1) the child is able to function acceptably in his natural environment (i.e., home and school), and (2) the parent or teacher has been taught procedures for managing the child constructively. Treatment data collected by parents and teachers, their verbal reports, and the treatment agent's opinion of treatment progress determine when the two criterion are satisfied.

Success rate =

$$\frac{A}{A+C+D+E+M+N+O} = \frac{324}{324+72+7+14+3+2+4} = \frac{324}{426} = 76\%$$

Subsamples: For those cases that were terminated after participating only in the summer, 1974 day care program and the residential treatment program, the success rates are calculated below:

Summer, 1974 Day Care Program =

$$\frac{A}{A+C+D+E+M+N+O} = \frac{4}{4+4+0+0+0+0} = \frac{4}{8} = 50\%$$

PST-Residential-PST Treatment Sequence =

$$\frac{A}{A+C+D+E+M+N+O} = \frac{70}{70+10+0+0+10+2+1} = \frac{70}{83} = 84\%$$

PST-Day Care-PST Treatment Sequence (7/76 to present)

$$\frac{A}{A+C+D+E+M+N+O} = \frac{15}{20} = 75\%$$
$$15+4+0+0+0+0+1$$

TABLE IV-1

TERMINATIONS

(8/73 - 12/6/76)

	Pendleton Code		No. of Cases
A	01	Change in behavior such that child is able to function adequately in the natural environment, including home and school.	324
B	02	Parents not interested in services at this time	74
C	03	Parents unwilling to accept services after treatment program implemented	72
D	04	School unwilling to accept services prior to implementation of treatment recommendations	7
E	05	School unwilling to accept services after implementation of treatment program	14
F	06	Referred to another agency for appropriate services	42
G	07	Change of residence resulted in no further need for services for child	4
H	08	Change in school placement resulted in no further need for services for child	25
I	09	Parents located another resource	28
J	10	Family moved outside Pendleton coverage area	23
K	11	Case referred but parents not following through	0
L	12	Inappropriate referral	31
M	13	Entered court system	3
N	14	Entered residential setting (non-Pendleton)	2
0	15	Tried everything but nothing worked	4

FOLLOW-UP CODES

(August, 1973 - November 30, 1976)

Pendleton Project Code			Number of Cases			
			1 month after term.	5 months after term.	12 months after term.	24 months after term.
A	01	Child continues to function adequately in his/her environment	297	193	102	14
B	02	Child exhibits the maladaptive behaviors for which he/she was originally referred at home	59	30	19	5
C	03	Child exhibits the maladaptive behaviors for which he/she was originally referred at school	61	73	44	8
D	04	Child exhibits maladaptive behaviors not originally identified as problems at home	3	6	0	0
E	05	Child exhibits maladaptive behaviors not originally identified as problems at school	3	2	0	1
F	06	Client exhibits no problem, but older siblings have begun exhibiting problems at home	0	0	0	0
G	07	Client exhibits no problem, but older siblings have begun exhibiting problems at school	0	0	0	0
H	08	Client exhibits no problem, but younger siblings have begun exhibiting problems at home	0	0	0	0
I	09	Client exhibits no problem, but younger siblings have begun exhibiting problems at school	0	1	0	0
J	10	Unable to contact family	50	37	72	38
K	11	Unable to contact referring agency	0	1	0	0

Follow-Up Codes continued

		Pendleton Project Code	Number of Cases: 1 month after term.	5 months after term.	12 months after term.	24 months after term.
L	12	Case reopened	21	33	23	2
M	13	Other (please specify)	8	8	0	1
N	14	Entered court system	9	12	12	4
O	15	Child has regressed, but behavior is still tolerable	7	12	5	0
P	16	Located another resource - school	1	4	0	0
Q	17	Located another resource - home	2	3	4	1

EFFECTIVENESS OF TREATMENT GAINS
AT FOLLOW-UP CONTACT

$$\text{Percentage of cases in which child is behaving acceptably} = \frac{A+O}{A+B+C+D+E+M+N+O}$$

$$\text{1 month after termination} = \frac{297+7}{297+59+61+3+3+8+9+7} = \frac{304}{447} = 68\%$$

$$\text{5 months after termination} = \frac{193+12}{193+30+73+6+2+8+12+12} = \frac{205}{347} = 59\%$$

$$\text{12 months after termination} = \frac{102+5}{102+19+44+0+0+0+12+5} = \frac{107}{182} = 58\%$$

$$\text{24 months after termination} = \frac{14+0}{14+5+8+0+1+1+4+0} = \frac{14}{33} = 42\%$$

Project Evaluation

During project management discussions in the early months of 1976, an idea began to emerge. It was believed that it would be prudent to have the project evaluated for effectiveness by an outside, unbiased agency. After investigation was conducted concerning the feasibility of such a maneuver, project evaluation was recommended. On June 17, 1976, Mr. W. D. Clark, chairman of the Project Management Board, presented a proposal for the evaluation to the executive committee of the Board. The proposal was submitted by Touche Ross & Company, a public accounting and business management firm of international reputation. The proposal was approved by the Board and the details for implementation of the study were worked out in ensuing months.

On September 8, 1976, the evaluation began with a three-week on-site visit by Touche Ross & Company, followed by their analysis and documentation of the study. About 400 man-hours were spent on this effort by Touche Ross & Company. Their final report was submitted on October 29, 1976. The summary chapter of that report is reproduced here.

I. MANAGEMENT SUMMARY

Purpose of the Review

The purpose of the management review of the Pendleton Project was to assess the Project's organization and management and to determine what actions are needed, if any, to improve the Project's operation. The review was focused on five major areas:

- Organization structure and management process
- Personnel management and staff development
- Client census and treatment
- Financial management
- Facilities

Our activities were performed during September and early October and consisted of the following:

- Interviews with:
  - Key Management Board members
  - All members of the Project management team
  - Eleven members of the clinical and administrative/ support staff
  - Director and staff of the Virginia Beach Department of Finance
- Documentation Review of:
  - 200 client records
  - Internal population reports
  - External reports
  - Current and previous budgets and cost data
- Analysis of:
  - Unit costs of care
  - Staff workload
  - Comparative costs
  - Facility lay-out and use

We have also met with the members of the Project's management team to discuss the findings and recommendations contained in this report.

Description of the Pendleton Project

The Pendleton Project is a community-based treatment agency which serves the cities of Virginia Beach and Chesapeake in the Tidewater area of southeastern Virginia. The Project was designed to identify and treat children between the ages of 6-12 who exhibit anti-social and maladaptive behavior. Through the use of behavior management techniques, the staff endeavors to reeducate the child and to reduce the incidence of these anti-social behaviors which cause problems for the child at home and in school and which may lead to juvenile delinquency.

The treatment program includes out-client services which are directed to working with parents and teachers to help them apply behavioral management techniques, residential care for the direct treatment of children with severe behavior problems, and a day care treatment program which is run primarily during the summer months.

The Project began its operational phase in July 1973 with out-client services. The residential program was implemented in the summer of 1974. At the same time the first summer day care program was conducted.

The primary source of revenue since the inception of the Program has been a grant from the Virginia Division of Justice and Crime Prevention. This grant has provided over 85 percent of all funding from August 1972 through June 1976, and 41 percent funding for the current fiscal year. The remainder of the current year's revenue will come from the State through House Joint Resolution #142. These funds have been supplemented by local human service delivery agencies which have contributed approximately half of the salaries of nine Pendleton staff members.

The Pendleton Project is somewhat unique and innovative in several respects. It was conceived as a treatment agency which would serve to foster inter-agency and inter-disciplinary cooperation at both the State and local levels. To this end, the Management Board is composed of representatives from 16 local and nine State agencies which are involved in the delivery of human services. In addition nine staff members, called "joint appointments," are hired directly from area agencies. Joint appointment personnel remain on the parent agency payroll and continue some involvement with the home organization while spending most of their time at the Pendleton Project.

The Project is also unusual because of its emphasis on ongoing treatment evaluation and analysis. This component of the Project is directed toward facilitating early identification of potential juvenile offenders, assessing overall treatment effectiveness of the Project, and identifying the types of treatment which are most effective with certain sub-groups of the population served.

Overall Conclusion

Day-to-day management and operations of the Pendleton Project generally function well, and we have identified five major strengths which we believe are the reasons for this favorable finding. However, we have also identified several areas where improvements, mostly long term in nature, should be implemented.

The thrust of the recommended improvements should be viewed within the historical context of the Pendleton Project's development. During the first three years of operation, the Project has experienced the problems which are often found in developing organizations. Management efforts have been directed toward making organizational and procedural changes in quick response to arising problems but has not systematically anticipated and dealt with problems in advance of their becoming "crisis" situations.

The Project is no longer in the developmental stage of operation. In order to remain a viable treatment agency and to continue to grow, management can no longer continue to manage primarily in response to internal and external issues. Management must take a more prospective, rather than reactive, role in managing the Project, by systematically and clearly defining its direction and goals for the future.

Major Program Strengths

During the course of our review we identified several areas of strength in the operation of the program. The major strengths are outlined in this section; others are identified in the body of the report.

1. The treatment objectives and methodology are clearly defined and are consistently carried out by program staff.

The review of client records and interviews with treatment staff members in both residential and out-client services indicated that:

- Treatment objectives for each client are defined, well-documented, and in consonance with the overall objectives of the program.
- Treatment methodology is thoroughly documented and, as indicated by the documentation, is apparently carried out in a consistent manner.

- Criteria for closing cases are clear and applied methodically.

- Follow-up procedures are carried out fairly systematically, with only a few exceptions noted.

2. Effective linkages have been established with State and area agencies which enhances interagency and interdisciplinary cooperation.

Community cooperation with the Project is evidenced by the fact that referrals from area agencies have increased steadily since the inception of the Project. The number of referrals received during the third year of operation ending on June 30, 1976, equaled the total referrals for the first two years combined.

The joint appointments of several staff members to the Pendleton Project and to other human service delivery agencies in the area have provided the Project with an interdisciplinary approach to treatment. It has served to facilitate the referral process and helps to avoid the duplication of services within the community.

The Management Board, consisting of representatives from 16 community and nine State agencies, has also helped to facilitate inter-agency communication and cooperation although the effectiveness of the Board in fostering cooperation has been limited by the large number of Board members and irregular Board member attendance.

3. The program includes ongoing activities directed toward improving program effectiveness and accountability.

The "research" component of the program is directly related to the treatment program and includes, but is not limited to, projects designed to:

- Identify the specific treatment approaches which are most effective with certain sub-groups of the population served.

- Measure the effectiveness of specific residential programs, using the results to modify the existing programs or to develop new ones.

- Develop a profile of the characteristics of the clients served to aid in early identification of children needing treatment.

There is evidence that the results of these "research" activities have been used to modify existing treatment programs and to develop new ones. The clinical effectiveness of specific treatment programs has also been tested.

4. The short- and long-term effectiveness of treatment is measured quantitatively for each client served.

Effectiveness of treatment is currently determined by three principal means:

- The frequency of client "target" behaviors is measured before, during, and after treatment, serving as an indicator of each clients' progress towards acceptable levels and types of behavior.
- Academic and personality tests are administered to children at the initiation and termination of the residential phase to determine the impact of the program in these areas.
- Although follow-up has always been a part of the program, new procedures have recently been instituted which provide for a more objective and quantitative evaluation of client behavior at stated intervals following the termination of treatment.

5. The staff is highly motivated and personnel turnover has been low.

In the last year, personnel turnover has been relatively low due to expressed staff satisfaction with their working conditions and the sense of accomplishment they have received. This is also evidenced by the fact that over half of the staff has been with the Project for over two years. The dedication of most of the staff, and particularly the management team members, became evident to us as we conducted our site review activities.

Areas for Improvement and Recommendations for Corrective Action

Although the Project exhibits numerous strengths, we have also identified areas in which management could implement changes resulting in more effective operation. Following is an outline of these areas and our recommendations for improvements.

1. Overall management of the Project has tended to react to short-term issues and has not paid sufficient attention to long-term concerns and the associated goal setting and implementation planning process needed to successfully deal with these concerns.

General, overall objectives for the Project have been defined; however, more specific annual operational goals for the Project have not been delineated. In the past this has resulted in the initiation of programs which had not been thoroughly planned prior to implementation, and the hiring of some staff before the need for the position had been fully determined.

In addition, there is evidence that available data regarding referral fluctuations, staff caseloads, client population figures and treatment costs have not been used effectively in planning and making management decisions throughout the program year.

In order to improve the effectiveness of the management process in actively directing the Project, we recommend the following:

- The management team should hold a planning session in the near future and continue to hold them annually. With Board and staff input, the team should outline specific goals for the remainder of the current fiscal year in areas such as funding, recruitment, research activities, professional speaking and training, and treatment program development. Each objective should include:

  - A clear statement of the desired result.
  - Specific action steps necessary to reach the goal.
  - Personnel primarily responsible for carrying out the action steps.
  - A timeframe for completion of the goal.

The team should meet at specified intervals to evaluate the Project's progress in each area, making modifications to the initial plan, as required. Examples of the types of goals and action steps that should be considered in the initial planning process are contained in the body of this report.

As part of the recommended planning process the management team should examine the available population and financial data quarterly using this information for decision making in the areas of staffing patterns and workload, cost effectiveness and treatment program planning.

2. <u>The recent hiring of an Administrative Assistant requires that his duties be clearly defined, particularly in reference to the Project Director</u>.

Specific recommended job responsibilities of the Administrative Assistant and the Project Director are detailed in the body of this report. In general, we recommend the following:

- The Administrative Assistant should be responsible to the Project Director for the administrative and support activities of the Project. His duties should include financial management, personnel management, direct supervision of the administrative/support staff, and community relations.

- The Project Director should continue to be responsible to the Management Board for overall program operation, and should be responsible for directing the program planning and evaluation process recommended above. In addition, emphasis should be placed on the clinical management and research aspects of the Project Director's job.

3. The broad range of the residential and out-client supervisors' responsibilities has prevented them from adequately prioritizing their activities.

The two treatment supervisors have responsibilities in the areas of administration, caseload management and supervision, personnel supervision, data collection and analysis, internal and external training programs, and treatment program planning. We recommend that each supervisor prioritize his activities and place greatest emphasis on those areas of greatest priority. Specifically:

- The out-client supervisor should concentrate on liaison activities with parent agencies and on his clinical responsibilities. He should de-emphasize his role in research activities and outside training at non-referral agencies.

- The residential supervisor should concentrate on treatment program development, particularly in the residential program, and on data collection and analysis. The daily operation of the residential program should become the primary responsibility of specified members of the residential treatment team with the supervisor continuing to maintain overall responsibility for the operation of the program.

The responsibilities of the two supervisors should be further delineated by the management team in the course of their goal setting activities.

4. The purpose of the Project's research activities and their relationship to treatment have not been clearly communicated to the Board or to present and potential funding sources.

Interviews with Board members and Pendleton personnel indicated that the research activities are not well understood by persons not directly involved with them. The research is sometimes viewed by "outsiders" as being an end in itself rather than as an integral part of the treatment program. In order to clarify the role of the research activities in the overall treatment program, we recommend the following:

- Reports addressed to funding sources and the community at large should include a clear, concise description

of the ongoing research activities and the necessity of these activities to the treatment process, written in terms easily understandable to the knowledgeable lay person. The details of the research design and data analysis, including the use of technical terminology, should be included as an appendix and forwarded only to those parties requesting it.

- The Management Board should be informed of the purpose and necessity of the research component and should periodically be apprised of the status and results of the various ongoing projects.

5. <u>The residential program has significant excess capacity of both personnel and facilities which could be better utilized</u>.

During the fiscal year 1975-76, the residential program operated at 58 percent of its full capacity of 14 children due to the lack of referrals of children requiring residential treatment. In light of recently published studies which indicate that many Virginia children with special problems must currently be sent outside the state for residential care, this underutilization may reflect the newness of the program and the lack of adequate community awareness of program capabilities rather than a saturation of community needs.

In order to use available residential resources more effectively, we recommend that the Project consider one or both of the following alternatives:

1. Undertake an organized program of working more closely with referral sources in Chesapeake and Virginia Beach to make the availability of Pendleton Project services better known and to reduce barriers and delays in the referral process;

2. Assess the number of children in the community for whom a day care program would be appropriate. At present residential census levels, a day care program capable of treating from four to eight children could be handled with existing staff and facilities.

The first alternative above should be made part of a planned community relations program which includes involvement of the recently formed Pendleton Project Advisory Council.

6. <u>Several staff positions were identified which do not appear to be necessary to the operation of the Project</u>.

In the course of our review we identified four staff positions which could be deleted without impairing the Project's operation. Removing these positions would result in annual savings of approximately $28,300.

We recommend that the Project carefully examine the necessity of these positions and make the appropriate reductions in staff. This is particularly important in light of the current funding situation.

* * * * *

Implication and Action

The wisdom of scheduling an independent evaluation of a project's operation during the project's third year was later validated by an independent source.

At the 84th convention of the American Psychological Association, a symposium was presented that addressed, among other things, program utilization (Breling, 1976). A development perspective was outlined for short-range, mission-oriented projects by the National Institute of Mental Health (NIMH), Center for Studies of Crime and Delinquency. The outline traced an eight-year interval which specified the R & D model adopted by NIMH.

Focused Activites	Starting Year
I. Model Development & Testing	2nd year
II. Project Evaluation by Independent Consulting Team	3rd year
III. User-oriented Information Dissemination	4th year
IV. Model-related Training	6th year
V. Evaluation of Model Replications in Service Settings	8th year

The Pendleton Project's first three years of operation has closely approximated this model. Furthermore, projected plans for future years are equally consistent.

As a result of the Touche Ross study, sixteen project goals have been identified and are currently being programmed for action.

A Management Sciences Institute sponsored by the U. S. Civil Service Commission titled *Project Management* was held in Norfolk, Virginia, on October 6-8, 1976, and was attended by Alan Davidson, Administrative Assistant to the Director of the Pendleton Project. A series of lectures was presented by Kenneth Bolton of Entrepreneurs International, Philadelphia, Pennsylvania. We have combined some of the procedures that Mr. Bolton discussed with those presented in the Department of Health, Education, and Welfare *Operational Planning System Handbook* (DHEW, 1972). These procedures have been adopted in order to organize and implement the project goals that were distilled from the *Touche Ross Final Report*.

The goals are stated here in descriptive terms. The page numbers that follow each goal refer to pages in the *Touche Ross Final Report* that specify material that is relevant to each goal stated on the list.

Among the project goals (page 90) that are now in progress or have been completed are #3, Survey the Need for Day Care Services; #4, Organize Routine Investigation of Funding Sources and Fee Scale; and #18, Organize Research Efforts and Expectations.

PROJECT GOALS

November 16, 1976

1. Monthly or bimonthly Progress Report. p.7, p.20.

2. Program to make project services better known to referral sources and to reduce barriers. p.8, p.16, p. 19, p. 28, p.29.

3. Survey the need for day care services. Questionnaire or experiment (i.e., Do It! and see). p.8, p.16, p.29.

4. Organize routine investigation of funding sources and fee scale. p.15, p.16, p.37, p.38.

5. Plan day care operation (see #3 above). p.15, p.16.

6. Determine duties of file clerk. p.15.

7. Organize procedures for public speaking requests and delivery. Professional meetings (i.e., giving or receiving). p.15, p.16.

8. Organize research efforts and expectations. p.16.

9. Plan new or modified treatment programs (re: #5 and #3 above) expanded caseloads. p.16, p.26, p.32.

10. Design procedure for board and staff input to goal setting. p.16.

11. Design deployment of staff according to seasonal changes in caseload, residential census, etc. p.17.

12. Develop a comprehensive, clear orientation program for new employees. p.18, p.19.

13. Design personnel evaluation procedures. p.20.

14. Improve record keeping of case files. p. 32, p.34.

15. Personnel audit and contingency. Plan for staff cuts (if necessary) p.35.

16. Formalize and clarify and document <u>all</u> procedures and relations with Department of Finance, funding agencies, and participating agencies. p.40.

Note: page numbers indicate reference material in the Touche Ross Final Report.

On the two pages that follow are two forms that are the major tracking instruments in our management by objectives system. The Project Description (page 92) format was borrowed from the Management Sciences Institute. The second form (page 93) is the milestone chart adopted from the HEW Operational Planning System. Other forms and procedures are also used but for the sake of brevity are not included.

Following the blank forms are the completed planning forms (pages 96 - 98) which are currently being used by the project management to track high priority goal #5, Plan Day Care Operations.

Completed to date in the day care operation is subproject Day School Need Assessment (#6) and a large portion of Identification and Recruiting (#1).

Each of the remaining goals will be planned separately, in accordance with this format and will be carried out to completion.

In the future, goals will be planned within the constraints of a Two-Year Operating Cycle (page 99). Because of the discipline of the budgeting process, goals must be formulated at least one year in advance of operation (page 100). The process follows the suggestion of Touche Ross and Company that the planning process occur far in advance of implementation.

PROJECT DESCRIPTION

- PROJECT
- DESCRIPTION
- GOAL
- STRATEGY
- SCOPE
- START/FINISH
- COST
- RESPONSIBILITY

  FUNCTION/ORGANIZATION INDIVIDUAL

- SUB-PROJECTS/OBJECTIVES

  DESCRIPTION RESPONSIBILITY

- ASSUMPTIONS

- PREPARED BY: APPROVALS:
- DATE: DATES:

The Pendleton Project

Fiscal Year _____

PROJECT: _____

Resources Required

Overall Evaluation

Milestones	Completion Dates																							
	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M

PROJECT DESCRIPTION

(an example)

Project: Day Care Program

Description: To provide day school program for children who need more than outclient service but not the residential treatment from The Pendleton Project.

Goal: To bridge a gap between family and the school when a child is identified as having severe school-related problems rather than the family problem, by not disrupting the natural home environment.

Strategy: To identify appropriate referrals to the day school program through human service agencies including school system, the project services team, and the parents.

Scope: (1) To put a child in a day school program from 4-6 weeks.
(2) To have about ten students in the day school while about ten residents are available.

Start/Finish: Year-round operation.

Cost: A part-time bus driver.

One more child care worker or a child care worker from second shift of Residential Treatment Team.

Responsibility:

Function/Organization	Individual
(1) Diagnostic & prescriptive function	Donna Beckett
(2) Teaching function	Jennie Andrews

Sub-Projects/Objectives:

Description	Responsibility
(1) Identification and recruiting	Richard Shea
(2) Bus driving	Alan Davidson
(3) Staff hiring in case of adding one more child care worker	Richard Pooley
(4) Staff reallocation	Bob Eun
(5) Second classroom operation	Donna Beckett/ Jennie Andrews
(6) Day school needs assessment survey	Richard Shea, Bob Eun, Alan Davidson
(7) An orientation brochure of day school program	Ann Ackerman

Assumptions:

(1) Day school program will bring more differential effectiveness of treatment for those who need the day school program service and meet the community needs.
(2) Day school program implementation would be contributing to reduce the residential program operational cost.

Prepared by: Dr. Bong-soo Eun

Date: November 30, 1976

The Pendleton Project

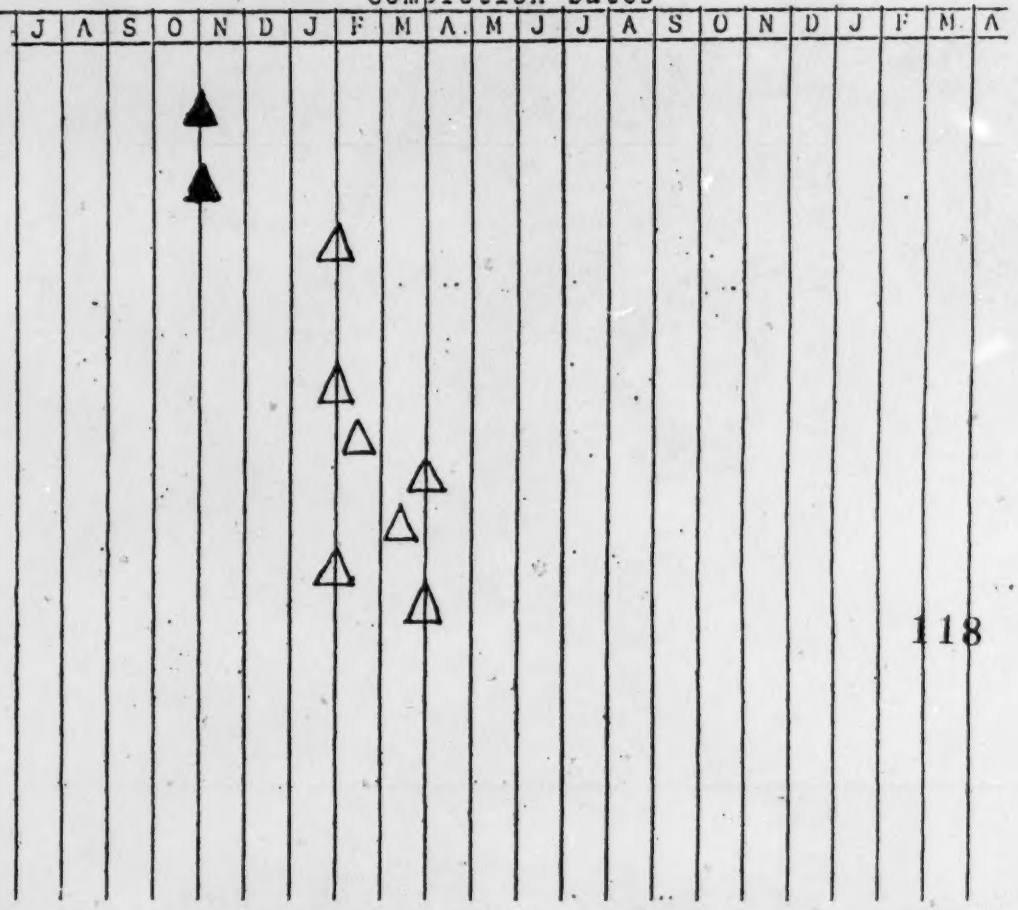
Fiscal Year 76-77

Resources Required

PROJECT: Day Care Program

Overall Evaluation

Milestones	Completion Dates
1. Identification and Recruiting	
a) Meet w/VB school officials to determine needs	
b) Meet w/Chesapeake officials	
c) Determine means for increasing present programs through school referrals	
2. Bus Driving	
a) Determine bus routing	
b) Schedule driving hours	
c) Determine drivers	
d) Personnel arrangements	
e) Bus equipment	
f) Receive/install equipment on buses	



The Pendleton Project

Fiscal Year 76-77

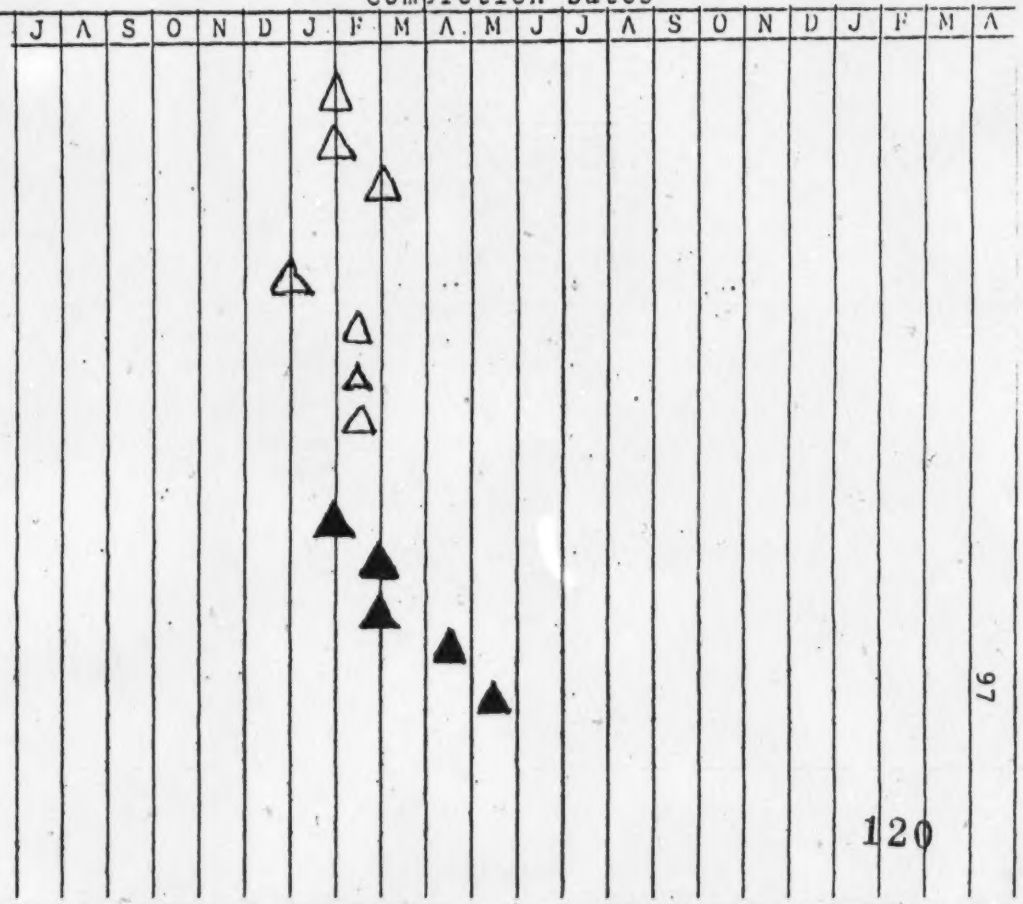
Resources Required

PROJECT: Day Care Program

Overall Evaluation

Milestones

Completion Dates



3 & 4. Staff Hiring or Reallocation

- a) Determine residential staff needs
- b) Determine financial capability
- c) Hire staff or reallocate

5. Second Classroom

- a) Decide client/classroom ratio
- b) Restructure building
- c) Determine staff allocation
- d) Organize teaching program

6. Day School Needs Survey

- a) Population identification
- b) Questionnaire design
- c) Mailing
- d) Response
- e) Compilation

The Pendleton Project
Fiscal Year 76-77

Resources Required

PROJECT: Day Care Program

Overall Evaluation

Milestones	Completion Dates
7. Orientation Brochure	
a) Narration	F
b) Design brochure	M
c) Printing	A

J A S O N D J F M A M J J A S O N D J F M A

THE PENDLETON PROJECT

Two Year Operating Cycle

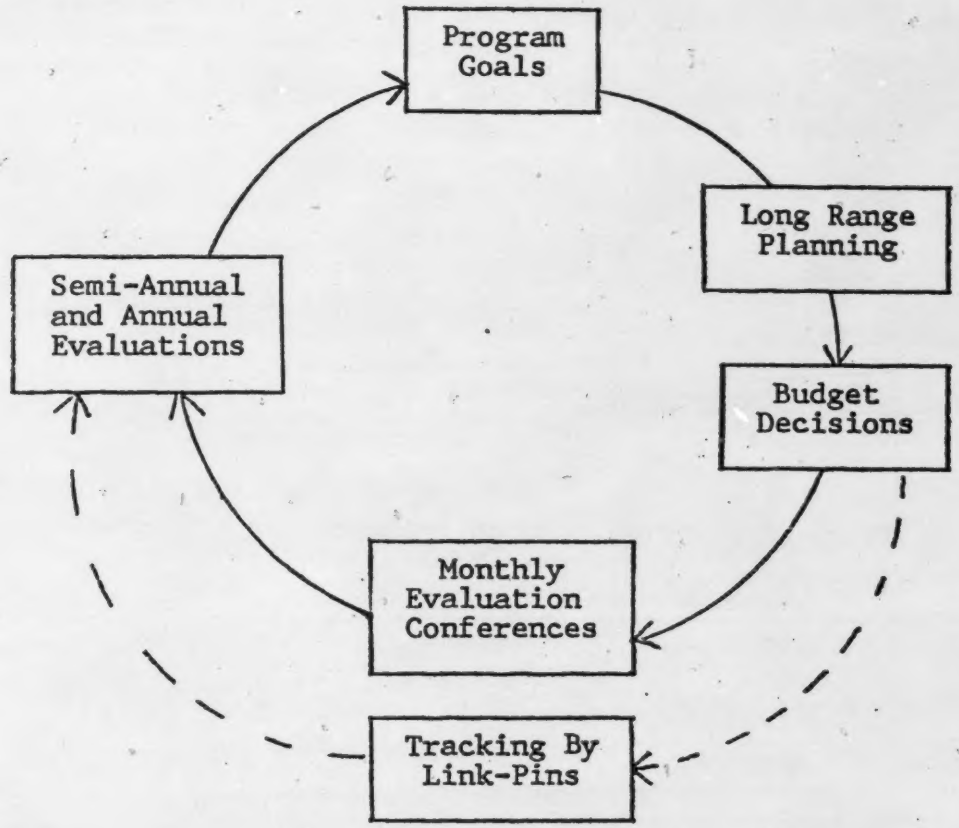


FIGURE IV-1

Figure IV-1 shows the two-year operating cycle of the Pendleton Project under the management by objectives system. The diagram is very similar to that used by HEW to illustrate the department's operational planning system.

In the first year, program goals are determined. Goals are then broken down into tasks, and individuals are assigned responsibilities. Long-range planning allows equipment and personnel needs to be determined one year in advance and incorporated into the budget which is formally submitted in October. Plans are then further refined until implementation in June of the following fiscal year. Goals are evaluated periodically and tracked to assure completion. On the following page is the Calendar for Management by Objectives. The calendar shows major tasks that must be completed each month to maintain the flow of the operating cycle.

The Pendleton Project

CALENDAR FOR MANAGEMENT BY OBJECTIVES

Date	Fiscal Year 77-78	Fiscal Year 78-79
June	Begin implementation of planned goals	Begin planning goals
July	Monthly evaluation conference	Continue planning - Begin budgeting decisions
August	Monthly evaluation conference	Complete resource and milestone charts
September	Monthly evaluation conference	Draft budget
October	Monthly evaluation con ference. Determine any necessary budget alterations	Submit budget to City Virginia Beach Finance Department
November	Monthly evaluation conference. Begin semi-annual evaluation	Formulate budget cut priorities
December	Monthly evaluation conference. Finish semi-annual evaluation	Budget conference with City of Virginia Beach Finance Department
January	Submit budget alterations to City of VB Finance Dept. Refine goals	Alteration of goals, if necessary after budget hearing
February	Monthly evaluation conference	Refinement of responsibilities for goals
March	Monthly evaluation conference	
April	Monthly evaluation conference year's goals	Prepare to implement
May	Monthly evaluation conference. Begin annual evaluation	
June	Monthly evaluation conference	

CHAPTER V

Project Management and Personnel

Management Board

Presented here is a detailed listing of the members of the management board for 1977-78 with executive committee members so noted by asterisks.

The follow officers were elected to the respective positions and assumed office on January 1, 1977.

Chairman:	Mr. Gordon Turner, Chief Juvenile Probation Department Municipal Center Virginia Beach, VA 23456
Vice Chairman:	Dr. Laura Morris, Director Department of Health Civic Center Chesapeake, VA 23320
Secretary:	Dr. John Aycock, Director Mental Health Services Board Pembroke I, Suite 103 281 Independence Boulevard Virginia Beach, VA 23462

PENDLETON PROJECT MANAGEMENT BOARD

*Dr. Laura Morris, Director
Dept. of Health, Civic Center
Chesapeake, VA 23320

*Mr. W. D. Clark, Director
Dept. of Social Services
100 Outlaw Street
Chesapeake, VA 23320

*Frances Elrod, Director
Dept. of Social Services
Municipal Center
Virginia Beach, VA 23456

*Gordon Turner, Chief
Juvenile Probation Dept.
Municipal Center
Virginia Beach, VA 23456

*Edwin S. Clay, III
Assistant to the City Manager
Municipal Center
Virginia Beach, VA 23456

*Ms. Vickie Montgomery
City Manager's Office
Chesapeake, VA 23320

*Charles H. Merritt, Assist.Comm.
Dept. of Vocational Rehabilitation
4615 W. Broad Street
Richmond, VA 23230

*William E. Weddington
Director of Youth Services
Dept. of Corrections
203 Turner Road
Richmond, VA 23235

Dr. Franklyn Kingdon
Assistant Superintendent
Dept. of Education
300 Cedar Road
Chesapeake, VA 23321

Chief R. A. Lakoski
Police Department
304 Albemarle Drive
Chesapeake, VA 23320

Donald Peebles
Chapter 10 Board
1301 Jerome Street
Chesapeake, VA 23324

Honorable Fred Aucamp
Juvenile & Domestic Relations Court
Municipal Center
Virginia Beach, VA 23456

Honorable E. P. Grissom
Juvenile & Domestic Relations Court
300 Cedar Road
Chesapeake, VA 23321

Dr. William Crawford, Director
Dept. of Public Health
Municipal Center
Virginia Beach, VA 23456

Dr. E. E. Brickell, Superintendent
Virginia Beach Public Schools
Municipal Center
Virginia Beach, VA 23456

Col. W. W. Davis, Chief
Dept. of Police, Municipal Center
Virginia Beach, VA 23456

Gary Farmer, Director
Juvenile Court Services
1202 - 20th Street
Chesapeake, VA 23320

Dr. John Aycock, Director
Mental Health Services Board
Pembroke I, Suite 103
281 Independence Boulevard
Virginia Beach, VA 23462

Dr. Samuel Graham
Director of Local Health Services
James Madison Building
Richmond, VA 23208

Ms. Jacqueline Raulerson, Reg.Rep.
Dept. Mental Health & Retardation
P. O. Box 1797
Richmond, VA 23214

Carl Cimino
Division of Justice & Crime Prevention
8501 Mayland Drive
Richmond, VA 23229

Miss Helen Hill
Dept. of Education
Ninth St. Office Building
Richmond, VA 23219

Pendleton Project Management Board continued

Ms. Jane Hotchkiss
State Dept. of Welfare
8004 Franklyn Farm Road
Richmond, VA 23288

Otis Brown
Secretary of Human Affairs
Office of the Governor
910 Capitol Street
Richmond, VA 23219

Maj. Gen. William J. McCaddin
National Guard
506 - 9th Street Office Building
Richmond, VA 23219

Mr. D. William Bridges
Representative, Advisory Council
Tidewater Community College
Princess Anne Road
Virginia Beach, VA 23456

Personnel

Presented here is the current distribution of staff together with the dates of employment. There are no anticipated terminations.

I. Administration

A. Director, Richard C. Pooley, Ph.D., 9/25/73

B. Administrative Assistant to the Director, Alan R. Davidson, M.B.A., 7/16/76

II. Clerical

A. Secretary II, Rosemary C. Spinelli, 4/7/75

B. Secretary I, Marilyn Trainer, 9/16/76

C. Account Clerk III, Alison Ruttenberg, 8/7/73

D. Clerk, Debbie Johnson, 9/13/76

III. Project Services Team

A. Virginia Beach Social Worker, Jean Wheeler, M.S.W, 9/16/76

B. Virginia Beach Probation Officer, Susan Woolf, B.S., 11/1/76

C. Virginia Beach Educational Specialist, Loneta Mooney, M.Ed., 7/1/76

D. Chesapeake Educational Specialist, Raymond Bloomer, B.S., 1/2/75

E. Chesapeake Social Worker, Sandra Nozzarella, B.S., 10/1/74

F. Virginia Beach Public Health Nurse, Billie Walker Johnson, R. N., 9/16/74

G. Comprehensive Mental Health Program, Psychiatric Social Worker, Catherine Chapin, M.S.W., 7/16/75

H. Chesapeake Probation Office, Peter Prizzio, M.Ed., 7/1/74

IV. Diagnostic Team

A. Clinical Psychologist, Richard Shea, Ph.D., 9/16/73

B. Educational Psychologist, Bong-soo Eun, Ph.D., 10/14/74

V. Residential Treatment Team

A. Teacher II, Fred Rowlands, B.A., 11/1/73

B. Teacher I

1. Henry Lee, B.S., Special Education, 7/15/74
2. Donna Beckett, B.S., Special Education, 8/7/74
3. Ann Ackerman, M.S., 7/1/75
4. Jennie Andrews, B.S., 8/7/74

C. Nurse, Dorothy Nichols, R.N., 7/28/75

D. Recreational Supervisor, Craig Johnson, B.S., 4/8/74

E. Behavior Technician I

1. Rose Marie Paganelli, B.S., 1/16/75
2. Jody DeCaro, 9/16/74

F. Child Care Workers

1. Shelid Stevenson, 4/16/74
2. Virginia Aygarn, B.S., 5/16/75
3. Donna Beasley, B.A., 5/5/76

VI. Residential Maintenance Staff

A. Custodian, Johnnie Brown, 1/28/74

B. Maintenance Mechanic, John Elliott, 9/16/74

C. Maintenance Mechanic Helper (made available through the Comprehensive Employment Training Act (CETA), Thomas Dulka, 11/1/76.

D. Cooks

1. Milford Dunbar, 6/24/74
2. Bettye Nickens, 9/3/74
3. Frances Williams, 10/1/74

VII. Substitutes

A. James Jard (M.A.)

B. Rebecca Reuzer (B.A.)

C. Donna McIntyre (B.A.)

D. John Eng (B.S.)

E. Susan Mintz (M.A.)

F. Brigidita B. Maliwanag

PENDLETON PROJECT ADVISORY COUNCIL

Virginia Beach

Bernard Barrow
3104 Arctic Avenue
Virginia Beach, VA 23451

D. William Bridges
4741 Red Coat Road
Virginia Beach, VA 23455

Michael Katsias
1720 Cooper Road
Virginia Beach, VA 23454

Lawrence B. Wales
212 - 40th Street
Virginia Beach, VA 23451

Mrs. Dorothy Wood
3809 Thalia Drive
Virginia Beach, VA 23452

Chesapeake

Russell Townsend, Jr.
205 Battlefield Boulevard South
Chesapeake, VA 23320

Ms. Margaret Perry
210 Robert Court
Chesapeake, VA 23320

Mr. W. A. Johnson
Chesapeake Schools
P. O. Box 15204
Chesapeake, VA 23320

Mr. Lloyd Gaskins
Chesapeake Schools
P. O. Box 15204
Chesapeake, VA 23320

Parents

Mr. Thomas Jackson
4120 Leyte Avenue
Chesapeake, VA 23324

Mrs. Bonnie Kerney
916 Old Dominion Lane
Virginia Beach, VA 23451

CHAPTER VI

Project Expenditure Analysis

Summary

Presented here is an expenditure analysis as of December 31, 1976. It should be noted that the analysis shows the disbursement of funds from two sources, the Department of Justice and Crime Prevention for personnel expenditures, and the House Joint Resolution No. 142 for all other expenditures.

The figures reflect all expenditures and encumbrances to date with the exception of $9,297.18 of personnel expenditures which are not shown. Agencies with whom two members of the Project Services Team share their joint appointment have not yet invoiced us for the months of July to December.

Currently, Old Dominion University is doing data processing work for the Pendleton Project on a contractual basis. No invoice has been received to date.

Expenditure Analysis
as of
December 31, 1976

Budget Categories	DJCP	Res. No. 142	Percent of Expenditures
FY '77 Appropriation	$200,556.00	$213,118.00	
Personnel	92,606.89	49,225.41	44.1%
Contractual Services		16,229.04	34.3%
Supplies		9,929.42	51.7%
Employers' Contribution		5,489.45	21.9%
Equipment		1,986.87	27.9%
Alterations & Additions		1,317.50	54.6%
Total Expenditures	92,606.89	84,177.69	42.7%
Balance	$107,949.11	$128,940.31	

Pendleton Project

House Joint Resolution No. 142

Service and Supplies - Itemized Expenditures

CONTRACTUAL SERVICES

Postage	$ 608.78
Telephone	1,504.44
Electric	1,180.12
Lease of Equipment	1,976.59
Legal & Expert Service	193.00
Dues & Subscriptions	586.50
Printing	87.50
Travel & Training	5,748.60
Sewage	86.33
Water	147.10
Laundry	527.71
Group Health Insurance	2,500.21
Repairs: Building & Grounds	158.75
Auto	138.30
Office Equipment	706.80
Allowances (client's Funds)	78.31
TOTAL CONTRACTUAL SERVICES	$16,229.04

SUPPLIES

Building Supplies	$ 684.87
Janitorial	353.01
Educational	485.13
Food	5,585.13
Gas, Grease & Oil	435.64
Office Supplies	1,817.44
Recreational	182.31
Small Tools	70.50
Materials & Supplies	95.60
Medical	40.63
Household	115.60
Photo Supplies	63.54
TOTAL SUPPLIES	$9,929.42

Appendix I

Caseload Statistics

PENDLETON CASELOAD UPDATE REPORT

I. TOTAL REFERRALS, August, 1973 to November 30, 1976

AGE	SEX		RACE			CHESAPEAKE AGENCIES							VIRGINIA BEACH AGENCIES							TREATMENT		TOTAL
	Male	Fm	B	W	O	Sch	S.S.	Crt.	PH	MH	Par.	Oth.	Sch	S.S.	Crt.	PH	MH	Par.	Oth.	In	Out	
6	50	16	11	55	0	5	3	3	1	0	4	1	16	4	0	1	2	16	10	8	58	66
7	55	15	12	58	0	13	1	2	1	0	4	1	18	3	2	0	1	19	5	13	57	70
8	73	14	19	68	0	15	5	5	0	0	2	2	20	6	4	1	6	16	5	12	75	87
9	98	8	27	79	0	19	8	5	0	0	5	0	27	7	7	1	3	20	4	21	85	106
10	109	13	40	82	0	27	4	4	3	0	8	1	30	9	8	1	1	19	7	28	94	122
11	120	23	36	106	1	25	13	8	0	0	12	3	29	8	9	0	4	26	6	29	114	143
12	137	22	47	111	1	33	13	17	0	0	9	2	24	6	17	0	7	28	3	30	129	159
TOT.	642	111	192	559	2	137	47	44	5	0	44	10	164	43	47	4	24	144	40	141	612	753

II. REFERRALS November 1, 1976 TO November 30, 1976

AGE	SEX		RACE			CHESAPEAKE AGENCIES							VIRGINIA BEACH AGENCIES							TREATMENT		TOTAL
	Male	Fm	B	W	O	Sch	S.S.	Crt.	PH	MH	Par	Oth.	Sch	S.S.	Crt.	PH	MH	Par.	Oth.	In	Out	
6	3	1	0	4	0	0	0	1	0	0	1	0	0	0	0	0	0	2	0	0	4	4
7	0	4	1	3	0	0	0	0	0	0	0	0	2	0	1	0	0	1	0	0	4	4
8	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1
9	2	2	0	4	0	0	0	0	0	0	1	0	0	1	1	0	0	1	0	0	4	4
10	4	0	1	3	0	0	0	0	0	0	1	0	1	0	0	0	0	2	0	0	4	4
11	6	1	1	6	0	0	1	0	0	0	0	0	5	0	0	0	0	1	0	1	6	7
12	6	0	0	6	0	2	0	0	0	0	0	0	2	0	0	0	1	1	0	0	6	6
TOT.	22	8	3	27	0	2	1	1	0	0	3	0	10	1	2	0	1	9	0	1	29	30

III. TOTAL TERMINATIONS, August, 1973 TO November 30, 1976

AGE	SEX		RACE			CHESAPEAKE AGENCIES							VIRGINIA BEACH AGENCIES							TREATMENT		TOTAL
	Male	Fm	B	W	O	Sch	S.S.	Crt	PH	MH	Par	Oth	Sch	S.S.	Crt	PH	MH	Par	Oth.	In	Out	
6	39	14	11	42	0	5	3	2	1	0	3	1	13	4	0	1	2	12	6	6	47	53
7	48	8	11	45	0	13	1	2	1	0	4	1	11	2	1	0	1	16	3	9	47	56
8	68	14	19	63	0	15	5	5	0	0	2	2	20	5	4	1	6	15	2	11	71	82
9	85	5	23	67	0	18	6	5	0	0	3	0	25	6	5	1	3	15	3	18	72	90
10	98	12	38	72	0	26	4	4	3	0	6	1	29	9	8	1	1	14	4	26	84	110
11	98	21	31	87	1	23	10	8	0	0	11	2	21	8	8	0	3	19	6	19	100	119
12	122	22	46	97	1	28	13	17	0	0	8	1	22	6	16	0	5	25	3	25	119	144
TOT.	558	96	179	473	2	128	42	43	5	0	37	8	141	40	42	4	21	116	27	114	540	654

Children in residence during the month: 12
Children in residence at the end of the month: 8

Children in day care during the month: 4
Children in day care at the end of the month: 3

111

Current Active Caseload: 99

QUARTERLY AND CUMULATIVE AVERAGES OF PROJECT SERVICES TEAM (PST) CASELOAD STATISTICS

	February, March, April, '75	Cumulative 3 month average	May, June, '75	Cumulative 5 month average	July, August, September, '75	Cumulative 8 month average	October, November, Dec., '75	Cumulative 11 month average	January, Feb., March, '76	Cumulative 14 month average	April, May, June, '76	Cumulative 17 month average	July, August, September, '76	Cumulative 20 month average	October, November, Dec., '76	Cumulative 23 month average	January, February, March, '77	Cumulative 26 month average	April, May, June, '77	Cumulative 29 month average	
1. Total active cases per month per PST worker	13.6	13.6	16.5	14.8	13.8	14.3	13.4	13.9	16.9	15.4	18.9	17.5	14.2	15.9							
2. Terminated cases per month per PST worker	3.2	3.2	4.6	3.9	3.1	3.5	2.3	2.9	3.7	3.3	4.8	4.1	2.8	3.5							
3. Mean treatment duration in weeks (all cases)	14.4	14.4	14.5	14.4	10.6	12.5	16.8	14.7	15.1	14.9	12.1	13.5	15.3	14.4							
4. Mean treatment duration in weeks (PST - RTT - PST sequence)	37.0	37.0	30.1	33.1	19.7	26.4	32.9	29.7	29.1	29.4	28.6	29.0	17.3	23.2							
5. Mean treatment duration in weeks (PST only)	10.3	10.3	10.6	10.4	8.6	9.5	12.6	11.1	13.7	12.4	9.9	11.2	14.4	12.8							

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